April 1, 1983

Ontario Health Insurance Plan

Schedule of Benefits

PHYSICIAN SERVICES

Ontario

Ministry of
Health

TABLE OF CONTENTS

Page

Preamble 1-32

Consultations and Visits 33-63

Nuclear Medicine 65-68

Therapeutic Radiology 69-70

Diagnostic Radiology 71-78

Clinical Procedures Associated with Diagnostic Radiological Examinations 79-81

Pulmonary Function Studies 83-84

Diagnostic Ultrasound 85-86

Diagnostic and Therapeutic Procedures 87-106

Obstetrics 107-110

Surgical Procedures—Preamble 111-114

Integumentary 115-124

Musculoskeletal 125-154

Respiratory 155-162

Cardiovascular 163-169

Haemic and Lymphatic 171-172

Digestive 173-190

Urogenital 191-198

Male Genital 199-202

Female Genital 203-208

Endocrine 209

Nervous 211-222

Organs of Special Senses 223-230

Laboratory Medicine L1-L22

PREAMBLE

A. General

1. The rates listed in this Schedule of Benefits are the maximum payments which can be made by the Ontario Health Insurance Plan.

2. Insured medical services are limited to the services which are medically necessary, which are listed in this Schedule of Benefits and which are not specifically excluded by legislation or regulation (see Appendix A for a list of specific exclusions).

3. Additions, deletions or other modifications of the Schedule of Benefits require recommendation by the Ontario Health Insurance Plan. Such recommendations are made in consultation with the Ontario Medical Association.

4. This Schedule is a public document and frank discussion with patients regarding the listed rates is recommended.

5. Claims for services which are not listed in the Schedule or which are listed as N.A.B. (not a benefit) or which are excluded as benefits by legislation or regulation should not be submitted to the Plan. Such services may be charged directly to patients or others requesting them.

6. The principles governing proper professional charges are incorporated in the Regulations (Medicine) of the Health Disciplines Act.

7. Each physician who participates in the care of a patient is entitled to compensation commensurate with the services he renders.

8. Whenever possible, the physician should acquaint the patient or person financially responsible with his obligations to those concerned with his care. This is particularly important where supportive or concurrent care is rendered or when a consultation and/or procedure are being arranged.

9. Each physician participating in the care of a patient should render to the patient, or to the financially responsible party, an itemized statement of charges for professional services.

10. Each physician participating in the care of a patient should, on request, send a receipt to the patient for all payments made by him.

11. If fees are collected by an organized group, the name of the physician rendering the service should be clearly shown on the bill or claim card.

12. Documentation: whenever a physician examines or treats a patient, an appropriate record of this service must be made and such record must be in keeping with section 29 of Regulation **448 of the Revised Regulation of Ontario 1980 under the Health Disciplines Act.** (see Appendix B).

13. Claims may be submitted for services which a patient receives from the team of staff man, resident, intern and clerk in a teaching unit, provided that the conditions as set out hereunder apply.

On October 10, 1972, the Minister of Health confirmed that the joint recommendations of the College and the O.M.A. governing the charging of fees for services provided by interns and residents in clinical teaching units are acceptable to the Ministry of Health. In his letter the

PREAMBLE

Minister made it very clear that he is looking to the College and the Medical Schools to ensure that the ethical rules governing these billing procedures are followed meticulously in all cases.

It has been carefully explained that the responsible staff man must be present in the clinical teaching unit at the time the services are rendered and must be identified to the patient at the earliest possible moment. No fees are to be charged for services given by the intern or resident prior to this identification taking place. The following rules are now in effect:—

When patient care is rendered in a clinical teaching unit or other setting for clinical teaching by a health care team, the physician responsible shall be personally identified to the patient. His relationship to the team shall be defined by the clinical teaching unit Director and his role must be known to the patient and other members of the team. He shall assume full responsibility for the appropriateness and the quality of the services rendered.

Specific regulations must vary with the service and form of care being delivered:—

(a) In order to claim for physical procedures being carried out by an intern or resident, the responsible staff man must be in the clinical teaching unit and immediately available to intervene.

(b) In pyschotherapy where the presence of the staff man would distort the psychotherapy milieu, it is appropriate for the staff man to claim for psychotherapy when a record of the interview is carefully reviewed with the resident and the procedure thus supervised. However, the time charged by the staff man may not exceed the total time spent by him in both such interview review and in direct supervision.

(c) In other departments or services, the staff man should only claim for visits on the days when actual supervision of that patient's care takes place through the presence of that staff man in the clinical teaching unit on that day. This, of course, involves a physical visit to the patient and/or a chart review with detailed discussion with the other member(s) of the health team.

(d) In those situations where on a regular basis a staff member might supervise concurrently multiple procedures or services through the use of other members of the team, the total claims made by the staff man shall not exceed the amount that the staff man might make in the absence of the other members of the team.

Any claim rendered should be in the name of the responsible staff man.

14. Charges for missed appointments are not benefits of O.H.I.P.

B. Terms and Definitions

Call or Visit: is the service by a physician to or on behalf of a patient for assessment and/or treatment.

1. **Consultations:**

(a) A consultation refers to the situation where a physician, in light of his professional knowledge of the patient, requests the opinion of another physician competent to give advice in this field, because of the complexity, obscurity or seriousness of the case or because another opinion is requested by the patient or an authorized person acting on his behalf. The consultant is obliged to perform a general or specific assessment, review the laboratory and/or other data and submit his findings, opinions and recommendations in writing to the referring physician.

(b) If a consultant is requested by a physician on duty in the emergency department to see a patient in consultation, the consultant may claim a consultation for this service. If the consultant is requested to perform this same service by a resident or intern, the consultant may claim a general or specific assessment according to his specialty.

(c) For laboratory and procedural benefits connected with consultations, see listings of Laboratory Medicine and Diagnostic and Therapeutic Procedures.

(d) A consultation is not to be claimed as such when:

  (i) The patient presents himself to a consultant's office without prior knowledge of the primary physician. The sending of a report to the primary physician under these circumstances does not justify a claim for a consultation.

  (ii) The primary physician is not asked for professional advice but is simply asked by the patient for the name of a specialist in a particular field and the patient seeks out the specialist himself.

(e) A diagnostic radiology consultation applies when radiographs made elsewhere are referred to a radiologist for his written opinion or when a radiologist is required to make a special visit at Night (5.00 p.m. to 7.00 a.m.), Saturdays, Sundays and Holidays to consult on the advisability of performing a diagnostic radiological procedure which eventually is not done. A consultation does not apply when the radiographs referred to above are used for comparison purposes with radiographs made in the consultant's facilities.

(f) A diagnostic pathology consultation applies when tissue slides are referred to a second pathologist for a written opinion. It includes secretarial or other assistance but does not apply when the tissue slides referred to above are used for comparison with tissue slides done in the consultant's facilities. When a diagnostic pathology consultation fee is claimed L821 may not also be claimed.

(g) A pathology consultation or repeat consultation applies when a pathologist is requested to examine a patient and provide a written opinion.

(h) A diagnostic nuclear medicine consultation applies when nuclear medicine studies are referred to a nuclear medicine specialist for a written opinion or when the nuclear medicine physician is required to make a special visit at night (5.00 p.m. to 7.00 a.m.), Saturday, Sunday or Holiday to consult on the advisability of performing a nuclear medicine procedure which eventually is not done. A consultation does not apply when procedures done elsewhere are used for comparison purposes with nuclear medicine studies made in the consultant's facilities.

(i) A nuclear medicine consultation or repeat consultation applies when a nuclear medicine specialist is requested to examine a patient and provide a written opinion, all of which takes a greater amount of time and effort than a nuclear medicine study would normally require. It may be done in conjunction with a nuclear medicine study but if so, the lesser professional benefit (P_2) rather than the greater benefit (P_1 should be claimed in addition to the technical (T) benefit.

(j) Some nuclear medicine specialists have other specialist qualifications which allow them to claim other consultation benefits (e.g., internal medicine). A nuclear medicine consultation or repeat consultation may be claimed in lieu of another consultation (e.g., internal medicine) but would not be combined with a claim for such a consultation by the same consultant.

(k) A prenatal consultation by a paediatrician applies when a physician considers a foetus of greater than 20 weeks gestation to be at risk or in jeopardy by reason of continuation of pregnancy in the presence of maternal and/or foetal distress, and requests the opinion of a paediatrician competent to give advice in this field. The paediatrician shall perform a general or specific assessment, review laboratory and other data and submit his findings and recommendations in writing to the referring physician. Such a consultation does not preclude the paediatrician from a postnatal consultation on the infant.

(l) **A special surgical consultation may apply when a surgeon provides:**

  (i) **All the components of a regular consultation but is required to spend considerably more time than is usual in consultation because of the very complex, obscure or serious nature of the problem;**

  (ii) **A tertiary consultation based on the foregoing criteria**

  The surgeon may claim for special consultations on an I.C. basis (see para 25 Section B)

(m) OHIP benefits for consultations normally are limited to one consultation per year, per patient, by any one physician. However, if the same patient is referred to the same consultant a second time within the year with a clearly defined unrelated diagnosis, one additional consultation may be claimed per year.

2. **Limited Consultation:** may involve all of the components of a full consultation but is less demanding, and in terms of time, normally requires substantially less of the physician's time than the full consultation.

3. **Repeat Consultation:** requires all of the criteria of a full consultation and implies interval care by the primary physician. The situation in which the consultant requests the patient to return for a later examination is not a repeat consultation.

4. **General Assessment:** shall comprise a full history, an enquiry into, and an examination of all parts or systems (and may include a detailed examination of one or more parts or systems), an appropriate record, and advice to the patient.*

OHIP benefits for general assessments normally are limited to one per year per patient by any one physician. However, if the same patient presents again within the year to the same physician with a clearly defined new diagnosis, one additional general assessment may be claimed per year. In the case of a patient who proceeds normally to hospital, the admitting physician may claim one additional general assessment per year provided 90 days have elapsed since the last general assessment rendered (anywhere) to that patient by the admitting physician. If the patient doesn't qualify for a general assessment by the admitting physician, he may claim a general re-assessment.

5. **General Re-Assessment:** shall comprise the same services as a general assessment except that the history need not include all the detail already obtained in the original general assessment.*

OHIP benefits for general re-assessments, except for hospital admission re-assessments, are limited to two per year, per patient, by any one physician.

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*For laboratory and other investigation performed in conjunction with a consultation or visit, see Diagnostic and Therapeutic Procedures and Laboratory Medicine.

6. **Specific Assessment:** shall comprise a full history of the presenting complaint, enquiry concerning, and detailed examination of the affected part, region or system, as needed to make a diagnosis and/or exclude disease and/or assess function, an appropriate record, and advice to the patient.*

Physicians qualified in two specialities (EENT for example) may only claim for one visit, eg: a consultation (if referred) or a specific assessment (if non-referred), if both systems are examined during the same visit. However, two consultations or two specific assessments, etc. may be claimed if both systems are examined, each on a separate visit.

OHIP benefits for specific assessments normally are limited to one per year, per patient, by any one physician. However, if the same patient presents again within the year to the same physician with a clearly defined new diagnosis, one additional specific assessment may be claimed per year.

7. **Specific Re-Assessment:** shall comprise a full relevant history and a comprehensive physical examination of one or more systems but not requiring an evaluation of the patient as a whole.*

This service is the admission assessment when the patient has been seen prior to admission in the same illness. It is included in the surgical fee except for those procedures marked I.O.P. Complete Care and Fractures and Dislocations requiring no reduction.

8. **Intermediate Assessment: is a primary care service for physicians providing general practice or paediatric services and** is a more extensive assessment than a minor assessment. It shall comprise a history of the presenting complaint(s), enquiry concerning and examination of the affected part(s), region(s), or system(s) or emotional disorder as needed to make a diagnosis, exclude disease and/or assess function, an appropriate record, and advice to the patient.*

9. **Multiple Systems Assessment:** shall comprise a detailed history and examination of more than one system, part or region, an appropriate record and advice to the patient.

10. Partial Assessment: shall comprise a history of the presenting complaint, the necessary physical examination, an appropriate record and advice to the patient. It also applies to subsequent visits for assessing the response to treatment and/or advice provided in a previous service.

11. **Minor Assessment:** is a brief assessment comprising the necessary history, examination of the affected part or region, an appropriate record and advice to the patient. It also applies to a subsequent visit solely for assessing the response to treatment of a previously diagnosed condition when the necessary examination and/or assessment reveals that no additional clinical assessment is required and none is performed.*

12. **Psychotherapy:** is any form of treatment for mental illness, behavioural maladaptations, and/or other problems that are assumed to be of an emotional nature, in which a physician deliberately establishes a professional relationship with a patient for the purposes of removing, modifying or retarding existing symptoms or attenuating or reversing disturbed patterns of

*For laboratory and other investigation performed in conjunction with a consultation or visit, see Diagnostic and Therapeutic Procedures and Laboratory Medicine.

behaviour, and of promoting positive personality growth and development. Accordingly, therefore, a psychotherapeutic procedure may be claimed if a half hour or major part thereof has been spent by a physician in such treatment of the patient. Psychotherapy may not be claimed by more than one physician for the same patient at the same time.

In order to qualify for a psychotherapy claim, a minimum of twenty minutes must be spent with the patient. When psychotherapy extends beyond thirty minutes, the major part (**16 minutes**) of the next half hour must be spent with the patient to qualify for an additional half hour fee. Similarly, after an hour of psychotherapy, the major part (**16 minutes**) of the next half hour must be spent to qualify for an additional half hour fee and so on." (Medical Review Committee Bulletin, Volume 3, Number 1.)

13. **Counselling:** as distinct from psychotherapy, counselling is that activity in which the physician engages in an educational dialogue with the patient(s) on an individual or group basis wherein the goal of the physician and patient(s) is to become aware of the patient(s) problems or situation and of modalities for prevention and/or treatment. Counselling is not intended for ongoing treatment or a substitute for a patient assessment, and it must be rendered personally by the attending physician.

Advice given during a visit for patient assessment and relative to that assessment (see definitions) is included in the assessment benefit and does not qualify for "counselling".

14. **Genetic Counselling:** includes interviewing the appropriate family members, the collection and assessment of adequate clinical and genetic data to make a diagnosis, construct a pedigree, and assess the risks to persons seeking advice. It includes imparting this information and the various alternatives to the appropriate family members in such a way that they can make informed decisions about dealing with the genetic problem.

15. **Examinations of Well Persons:**

(a) **Age:** (unless otherwise specified)
Newborn — up to 10 days of age.
Infant — up to 2 years
Child — up to and including 15 years
Adolescent — up to and including 17 years
Adult — 18 years or over.

(b) **Newborn Care:** is the routine care of a well baby up to ten days of age and should include a complete physical examination of the baby and necessary instructions to the mother. The service shall involve at least two visits, and normally may not be claimed for the same patient by more than one physician.

When a well baby is transferred to another hospital (because of the mother's state of health, for example) claims for newborn care by a physician at each hospital may be appropriate.

(c) **Low Birth Weight Care:** is the care of a baby weighing less than 2.5 kilograms at birth.

(d) **Well Baby Care:** the periodic visits of a well baby during the first two years of life involving complete examination with necessary weight and measurements and instructions to the parent(s) regarding health care.

(e) **Annual Health or Annual Physical Examination** (Including Primary and Secondary School Examinations): shall comprise all the elements of a general assessment as it pertains to an individual who presents and reveals no apparent physical or mental illness. O.H.I.P. benefits for any one physician are limited to one Annual Health Examination per patient per year after the second birthdate. To qualify for O.H.I.P. benefits, an Annual Health Examination normally must be requested by the patient rather than a third party. Under Regulation 452 of Revised Regulations of Ontario, 1980 under the Health Insurance Act, examinations for the purpose of "legal requirements or proceedings" are excluded from coverage. However, it is recognized that an Annual Health Examination will satisfy some or all of the requirements for examinations required by statute but excluded by the above mentioned Regulation. In such instances and where a prior claim for an Annual Health Examination has not been submitted to the Plan in the previous twelve months for that patient, it would be appropriate to submit a claim to OHIP for this service. The OHIP benefit in these cases covers the Annual Health Examination only and not any charges peculiar to the legal requirements, such as charges for the completion of forms.

(f) **Predental General Assessment: Is the history and examination of a patient required prior to dental surgery under anaesthesia in hospital. A diagnosis is not required by OHIP for this service.**

Other Terms, Definitions and Guidelines

16. **Coding:** This schedule lists a code number opposite most items. Items which are not coded are identified either as U.V.C. or N.C.

U.V.C.— use visit codes applicable to the pertinent service and specialty.

N.C.— no code applicable. This service is not a benefit (N.A.B.) of O.H.I.P., and may be charged directly to patients.

For the surgery portion of this schedule, physicians submitting claims in coded form should add to the code numbers, the suffix A if they perform the procedure, the suffix B if they have assisted at the surgery or the suffix C if they have administered the anaesthetic.

For those diagnostic and/or therapeutic procedures which have the technical and professional components listed separately, but under the same code, the suffix A should be added to the code numbers when both components are being claimed, the suffix B when only the technical component is being claimed, or the suffix C when only the professional component is being claimed.

Where separate codes are listed for the technical or the professional components, the suffix A should be used.

For diagnostic radiology, only one code is listed for each service, even though some of these services may be provided by non-certified radiologists. The code for services rendered by non-certified radiologists should be obtained by increasing the first digit in the listed codes by 5. Thus, for example, the code for the service listed as X001 but rendered by a non-certified radiologist would be X501 plus the appropriate suffix.

17. **General Listings:** include the basic listings for consultations, assessments and other visits wherever they are rendered, except for non-emergency services to hospital or long-term care institution in-patients and for care rendered by a physician on duty in an emergency department. These latter services are listed separately in the Schedule.

A visit rendered to a patient in a rest home, lodge, detoxification centre, half-way house, or other institution not covered elsewhere in the Schedule, should be claimed under the General Listings.

PREAMBLE

18. **Non-Emergency Hospital In-Patient Services:** include the listings for consultations and other visits to registered bed patients.

(a) The general assessment, general re-assessment, specific assessment or specific re-assessment rendered in conjunction with a patient's admission to hospital is considered to be the hospital "admission assessment". Such assessments may not be claimed more than once during a hospital admission even if a patient's care subsequently is transferred to another physician. Moreover, such assessments may not be claimed by a consultant who also is claiming a consultation in conjunction with the patient's admission to hospital. Such consultation by the admitting physician serves as the admission history and examination.

(b) Subsequent routine visits should be claimed as "subsequent visits (minor assessments)" Claims for daily hospital visits must not be made unless a physician actually visits the patient each day. Prior to the weekly and monthly limitations that apply after a patient has been in hospital for 5 weeks (6 weeks for paediatricians), payments for hospital visits generally are limited to one per patient per day. For acute illnesses or exacerbation of original illness requiring additional visits before or after 5 weeks of hospitalization, claims for extra visits should be made on an independent consideration basis. **In the case of a protracted terminal illness, additional hospital visits rendered, will be accepted on an independant consideration basis for a maximum of 4 weeks.**

(c) When a patient in hospital is referred by one physician to another, the second physician will not be limited by the Subsequent Hospital Visit formula for the number of hospital visits already rendered by the first physician. In other words, the second physician is entitled to claim for his visits up to five weeks just as if the patient was being attended to in hospital for the first time. However, if the patient is transferred to the care of another physician, the Subsequent Hospital Visit formula would apply just as it would if only one physician was involved in the care.

(d) When a physician already is in the hospital and is asked to assess one of his own in-patients on a non-emergent or emergent basis, the subsequent hospital visit listings apply. However, if he is asked to assess another physician's patient on an emergent basis, the General Listings should be used.

19. **Emergency Department — Physician on Duty Services:** include the listings for minor and multiple systems assessment and the specific premiums applicable to the services rendered by the physician on duty. A physician on duty in the Emergency Department regardless of his specialty should submit claims under these listings. A physician who is not on duty in the Emergency Department should use the General Listings when seeing patients in the emergency or out-patient departments. See Appendix C for further guidelines to claiming for services rendered in the Emergency Department.

20. **Long-Term Institutional Care:** includes the listings for consultations, assessments and other visits to patients in chronic care hospitals, convalescent hospitals, nursing homes and other institutions in which such patients are covered by extended care legislation.

Admission assessments to long term care institutions are classified as —

Type 1 — applies when the admitting physician has not performed a consultation, general assessment or general re-assessment prior to admission and when he carries out a general assessment (on admission) and provides a report for the medical record.

Type 2 — applies when the admitting physician has performed **and claimed** a consultation, general assessment or general re-assessment prior to admission, makes an initial visit and records an admission note describing the condition of the patient following admission.

When a physician already is in the institution and is asked to assess one of his own in-patients on a non-emergent or an emergent basis, the subsequent visit listings apply. However, if he is asked to assess another physician's patient on an emergency basis, the General Listings should be used.

21. Subsequent visits to Long Term Care Institutions: include the supervisory care as well as the active treatment of acute intercurrent illness when the physician is already in the Long Term Care Institution. The supervisory care component includes discussion with the patient and/or examination, and also includes, as required, discussion with the nurse, a chart review and annotation of the chart. When acute intercurrent illness requires a special visit, the appropriate fees under General Listings and Premiums will apply.

22. **Visit for Procedure:** when the sole reason for an office visit is the performance of a certain procedure, the listed benefit for the procedure will apply. (See Diagnostic and Therapeutic Procedures Preamble for exceptions.) When procedures are carried out in the office, emergency or outpatient department on an elective basis, a special visit should not be claimed in addition to the procedural fee.

When procedure(s) are carried out by a physician's employee(s) under the direct supervision of the physician, the usual claims may be made for procedure(s) which are generally and historically accepted as those which may be carried out by the nurse or other medical assistant in the employ of the physician. "Procedures" in this context do not include such services as assessments, consultations, psychotherapy, counselling, etc. Direct supervision requires that during the procedure the physician be physically present in the office or clinic at which the service is rendered.** While this does not preclude the physician from being otherwise occupied he should be in personal attendance on enough occasions to ensure that procedures are being performed competently and he must at all times be available immediately to approve, modify or otherwise intervene in a procedure as required in the best interests of the patient.

For physiotherapy procedures performed under direct physician's supervision as detailed above, see Code G467 on Page 105.

23. **Premiums:**

(a) **Special visit fees chargeable in addition to benefits for services listed under consultations and visits, critical care and injections or infusions.**

- (i) A special visit is one which is initiated by the patient or his representative which requires a physician to travel from one location to another to see a patient(s). That is, when the physician is not already in the office, hospital, institution, patient's home, etc. and is called to make a special trip there to attend a patient, a "special visit" premium may be claimed. The premium(s) for a special visit to the office only applies outside of normal office hours but does apply whether or not the office is in the physician's home.
- (ii) The special visit premiums apply only to emergent or non-elective calls and do not apply to non-referred or transferred obstetrics. The premiums do not apply to visits on regular rounds, and admission assessments of patients who have been admitted to hospital, etc. on an elective basis do not qualify as "special visits", regardless of the time performed.
- (iii) If an institution has arranged to have quarters in the same or in a proximal building in order that a physician will be available to make visits to the institution, particularly at night, these are not considered to be "special visits" to the institution.

**Some procedures may not require the physical presence of a physician for adequate supervision. Exceptions to this requirement of direct supervision may be made upon recommendation of the Ontario Medical Association and the College of Physicians and Surgeons of Ontario.

When services are rendered on an emergency basis at a site other than listed in this schedule (e.g. roadside, ski slope, etc), the special visit premiums are applicable.

If a physician is called to pronounce a patient dead, a minor assessment may be claimed along with the appropriate surcharge for the special visit.

(iv) An emergency call with sacrifice of office hours may be claimed in a situation where the demands of the patient and/or the physician's interpretation of the patient's condition is such that the physician responds immediately at the sacrifice of regular office hours.

(v) A special visit at night or on a Saturday, Sunday or holiday may be claimed when non-elective or emergent calls are made between the hours of 5.00 pm and 7:00 am or are received and made on Saturdays, Sundays and Holidays. "Holidays" are defined for the purpose of this schedule as New Year's Day, Good Friday, Easter Monday, Victoria Day, Dominion Day, Civic Holiday, Labour Day, Thanksgiving, Remembrance Day, Christmas Day and Boxing Day. If any of these holidays fall on a Saturday or Sunday, at the physician's discretion either the Friday before or the Monday following will be recognized as the holiday.

(vi) Only one special visit premium (daytime; sacrifice of office hours; or nights, Saturdays, Sundays and Holidays) may be claimed for the same patient, same visit, and does not apply to non-referred or transferred obstetrics.

(vii) The Home Visit premiums apply to emergent or non-elective assessments which are initiated by a call from the patient or his representative. It is recognized, however, that a home visit occasionally may be required because of the patient's medical condition even though the physician has not been called specifically for that visit. For such "elective home visits", the daytime special visit premium B990 is applicable in addition to the appropriate assessment under the General Listings. The Special Visit premiums applicable to nights, Saturdays, Sundays, Holidays or sacrifice of office hours, however, are not appropriate, regardless of the time of the visit.

(viii) Normally, the "additional patient" premiums are not applicable unless the additional patient himself qualifies for a special visit. Patients who drop in to the office or Emergency Department while the physician is there for reasons other than rendering a special visit at that time do not qualify for any of the special visit premiums. However, extra patients during a home visit or those who drop in to the office or Emergency Department while the physician is there rendering a special visit to another patient also qualify for the "additional patient" premiums if an assessment is rendered.

Extra in-patients seen during a special visit to a hospital or other institution do not qualify for "additional patient" premiums unless the physician has been asked specifically to see these extra patients as well. (See also paragraph 18(d) above.)

Patients seen during "office hours" held at night or on Saturdays, Sundays or Holidays do not qualify for any of the special visit premiums.

(ix) **When no consultation or visit fees are chargeable e.g. for postoperative hospital visits by operating surgeon, the minimum premiums for special visits apply for additional patients seen during a special visit. Minimum premiums also apply to additional patients seen requiring critical care (excluding Respiratory Care and Neonatal Intensive Care), Injections or Infusions.**

PREAMBLE

Special Visit Benefits: Applicable in addition to benefits for services listed under Consultations and Visits, Critical Care **and Injections or Infusions** K992, C992, K993, C993 also are applicable to assistant and/or anaesthetist at emergency surgery.

(x) Daytime (Monday to Friday) special visit to Emergency Department or O.P.D.
K990 First patient assessed . . . . add $11.50
K991 For each additional patient requiring a special visit and assessed during same special visit, add 20% to the assessment fee. . .minimum $5.40.

(xi) Emergency call with sacrifice of office hours —
K992 first patient assessed . . . . add $23.00
K993 for each additional patient requiring a special visit and assessed during same special visit add 20% to assessment fee . . . . minimum $7.15

(xii) **Evenings**, Saturdays, Sundays, Holidays (5:00 p.m. to midnight) —
K994 first patient assessed . . . . add $23.00
K995 for each additional patient requiring a special visit and assessed during same special visit add 20% to assessment fee . . . . minimum $7.15
Nights (midnight to 7:00 a.m.)
K996 First patient assessed . . . . add $34.40
K997 For each additional patient requiring a special visit and seen during the same special visit, add **50%** to the assessment fee . minimum $10.70

(xiii) Special visit to office —

The above benefits apply, but the prefix "A" should be substituted for the prefix "K" in the code (e.g. A990 instead of K990).

(xiv) Special visit to patient's home —

The above benefits apply, but the prefix "B" should be substituted for the prefix "K" in the code (e.g. B992 instead of K992).

(xv) Special visit to hospital in-patient —

The above benefits apply, but the prefix "C" should be substituted for the prefix "K" in the code (e.g. C992 instead of K992).

(xvi) Special visit to long-term care institution —

The above benefits apply, but the prefix "W" should be substituted for the prefix "K" in the code (e.g. W992 instead of K992).

(xvii) Special visit to any setting not listed above, or emergency services at the roadside, ski slope, etc.

The above benefits apply, but the prefix "Q" should be substituted for the prefix "K" in the code (e.g. Q994 instead of K994).

(xviii) Non Elective Surgical Procedures or Clinical Procedures Associated with Diagnostic Radiological Examination: — when such procedures including **obstetrics,** fractures or dislocations or **major invasive procedures contained in the list of Diagnostic and Therapeutic Procedures or elective procedures which because of intervening emergency procedure(s) commence after 5:00 p.m. and before midnight or on Saturdays, Sundays and Holidays, increase the procedural fee(s) by 20% (**E409**). When the foregoing procedures commence after midnight and before 7:00 a.m. any night during the week, increase the procedural fee(s) by 50% (**E410**).

These premiums are not chargeable in addition to the obstetrical fee(s) if labour is induced by medical and/or surgical means by the same physician. However, a forewater A.R.M. or oxytocin augmentation of labour carried out on a patient in desultory labour does not constitute induction.

PREAMBLE

These premiums are not chargeable (during or after a "shift") by **emergency** or other physicians who have elected or are required to be physically and continuously present in the Emergency Department or environs for an arranged designated period of time.

****Major Invasive Procedures are considered to be the following:**

G211 G246 G254 G264 G265 G266
G267 G268 G269 G270 G275 G277
G280 G285 G287 G288 G290 G291
G292 G293 G294 G295 G302 G303
G304 G323 G324 G327 G328 G329
G330 G331 G332 G347 G348 G349
G380 G398 G399 G411 G412 G418
R833 R840 R841 R843 R849 R850
R851 R852 R853 R854 Z804 Z805

E409 or E410 may not be claimed for procedures which mainly involve the interpretation of test results and are not applicable to assessments or consultations. Neither are they applicable to physicians on duty in the emergency department nor to procedures listed in the Diagnostic Radiology, Nuclear Medicine or Diagnostic Ultrasound sections of the Schedule.

(xix) Non-elective Nuclear Medicine, Diagnostic Radiology, Laboratory Medicine or Diagnostic Ultrasound Examinations.

C109 For special visits, evening (5:00 p.m. to midnight) or before midnight, Saturdays, Sundays or Holidays to perform examinations listed in the Nuclear Medicine, Diagnostic Radiology, Laboratory Medicine or Diagnostic Ultrasound sections of the Schedule, a premium of $23.00 may be added to the benefit for the first examination performed on any one patient or may be claimed alone if it is decided that the procedure is not medically indicated and a consultation is not rendered.

C110 For such special visits commencing between midnight and 7:00 a.m., the applicable premium is $34.40.

(xx) Assistants' services —

E400B For **all** cases commencing after 5:00 p.m. and before midnight or before midnight on Saturdays, Sundays and Holidays, the total benefit for assistant units (basic and time) is increased by 30%.

E401B For **all** cases commencing after midnight and before 7:00 a.m., the total benefit for assistant units is increased by **50%**.

(xxi) Anaesthetists' services —

E400C For **all** cases commencing after 5:00 p.m. and before midnight or before midnight on Saturdays, Sundays and Holidays, the total benefit for anaesthetic units (basic and time) is increased by 30%.

E401C For **all** cases commencing after midnight and before 7:00 a.m., the total benefit for anaesthetic units is increased by **50%**.

For cases requiring a special visit to the hospital, an additional premium of $3.60 (C998C) during the 30% premium period and $7.15 (C999C) during the 50% premium period may be charged to the first patient treated on each special visit.

(b) **Special Care Unit (e.g. I.C.U. or C.C.U.) —**

C101 **For each patient seen on visit to** I.C.U. or C.C.U. (excluding supportive care), add $5.70 to charges for all such visits.
Note: Where visit is not chargeable,
e.g. post operative care by surgeon, claim only **C101**
(excluding Supportive Care, Respiratory Care and Neonatal Intensive Care)

24. **Detention:** benefits may be applicable for detention when under very exceptional circumstances a physician is required to spend considerable extra time with a patient. Such extra time must be **spent in active treatment of the patient,** and it must be to the exclusion of all other work.

Claims for detention must be substantiated by an explanation on the claim card or in an accompanying letter, and should be made on an "I.C." basis according to the following guidelines:

After twenty minutes if the physician spends more than this amount of time providing a minor, **partial** or intermediate assessment or subsequent hospital visit;

After forty minutes if the physician spends more than this amount of time providing a specific or general re-assessment or multiple systems assessment or certification of mental illness;

After one hour if the physician spends more than this amount of time providing a consultation, limited consultation, repeat consultation, prenatal consultation, specific or general assessment.

Detention is not meant to apply to procedures nor to obstetrical care and does not include time waiting for X-rays, lab reports, the operating room or for the patient to arrive for assessment or treatment.

K001	Detention, per quarter hour or part thereof	$13.80
K101	Detention, while in attendance with patient(s) in ambulance, per quarter hour or part thereof	$23.00

Note: K101 is not applicable to attendance in a vehicle other than an Ambulance.

25. **Independent Consideration — "I.C.":** independent consideration will be given by O.H.I.P. for those items in the Schedule of Benefits which are listed as I.C.. Claims rendered under this heading must include a specific charge along with a detailed explanation of that charge. Where pertinent, an operative report or Consultation report is very helpful in rendering independent consideration. It also is helpful if I.C. claims include a comparison of the scope and difficulty of the procedure with other specific procedures listed in the Schedule.

26. **Transferral and Referral:**

(a) A referral takes place when one physician requests for his patient the services of another. The services of the latter may consist of:
- (i) an opinion (i.e. a consultation)
- (ii) diagnostic tests or procedures (e.g. skin test, biopsy, etc.)
  Note: In such cases the referring physician continues to treat the case himself.
- (iii) treatment (surgical or medical).

The referring physician's O.H.I.P. registration number must be included on the claim submission.

(b) A transferral, as distinguished from a referral, takes place where the responsibility for the care of the patient is completely transferred permanently or temporarily, from one physician to another in the same field or specialty (e.g. where the first physician is leaving temporarily on holidays and unable to continue to treat the case). The physician to whom the patient is transferred should be regarded as substituting for the other physician and is not entitled to claim for a consultation. Physicians who are substituting for other physicians should consider that patients of the latter have been temporarily transferred (not referred) to their care. Where the care of the patient involves a benefit containing several components such as surgery the physicians may consider the surgical benefit a team benefit and decide among themselves how each is to be compensated; traditionally physicians in these circumstances have reciprocated by exchanges of coverage for each other. When physicians routinely or frequently substitute for each other providing hospital visits to registered bed patients in active treatment hospitals, e.g. weekend coverage or daily rounds by various members of a group, the most responsible physician may claim for all the visits.

27. **Most Responsible Physician:** is the attending physician who is primarily responsible for the day to day care of the patient in hospital. In cases of unusual severity where the consultant assumes the role of the most responsible physician, the consultant may claim on a per visit basis and the family physician may claim supportive care. Where the family physician remains the most responsible physician and requests only a consultation, the family physician may claim on a per visit basis and the consultant may claim for a consultation only.

28. **Concurrent Care:** when the family physician remains the most responsible physician but because of the seriousness or complexity of the condition, requests continued directive care by a consultant, the family physician may claim on a per visit basis. The consultant also may claim on a per visit basis, not to exceed four such claims during the first week of concurrent care and not to exceed two such claims each week thereafter while the patient's condition remains serious — this arrangement being agreeable to both physicians.

29. **Multidisciplinary Care:** applies when the complexity of the medical condition requires the services of several physicians in different disciplines. In such cases, each physician should render a separate claim on a per visit basis. This does not refer to a situation where a single benefit for a team of physicians is listed in the Schedule.

30. **Supportive Care:** is the care rendered in hospital by the referring physician, who is not actively treating the case (e.g. writing orders), to a patient under the care of another physician, at the desire of the patient or family, for purposes of liaison or reassurance. The physician may claim for this care on a per visit basis, not to exceed four such claims during the first week of supportive care (**determined by the date of the first supportive care visit**) and not to exceed two such claims each week thereafter. If medical complications develop or are present in the post-operative period which require active management by the referring physician, claims for hospital medical care should be rendered, not supportive post-operative care.

31. **Long Term Terminal Cases in Hospital: applies to one designated physician responsible for the care of a terminally ill patient. Terminal care will be deemed to start when care is directed to maintaining the comfort and emotional well being of the patient and non aggressive treatment of the underlying disease process. For visits rendered to the terminally ill patient, see Preamble, Section B, paragraph 18 (b).**

PREAMBLE

32. **Specialist:** a specialist shall be defined (for purposes of application in the case of any given service within this Schedule) as one who holds a certificate from the Royal College of Physicians and Surgeons of Canada in the specialty which normally is considered to encompass the service in question.

A specialist rendering services outside of his specialty should use the codes and tariffs listed in the General Practice section of the Schedule

33. **Differential Benefits:**

(a) Where only one **procedural** benefit is listed, it **shall** apply to any physician rendering the service, regardless of specialty.

(b) **Specialists providing primary care in general practice may claim the appropriate visit fees as defined in the Preamble listed under the heading Family Practice and Practice in General. Certain other non specialist services such as counselling and interviews are under the same heading for the use of any physician providing such services.**

(c) Specialists in paediatrics who practice allergy may claim specialist rates for their allergy services regardless of the age of their patients.

34. **Referring Physician's Services:**

(a) For the services rendered prior to an operation, the referring physician should claim on a "fee-for-service basis", for example:
  (i) Home, Office or Hospital Visits as rendered.
  (ii) In addition to (i) above, in acute cases, benefits may be claimed for detention if applicable and appropriate (refer to paragraph 24, above).

(b) (i) For services rendered as an assistant during the operation, the referring physician should claim in accordance with paragraph 35, below.
  (ii) In cases in which the referring physician is required to be present in the interest of the patient but does not actually assist at the surgical procedure, he should claim a hospital visit for this service.

(c) For the services rendered after the operation, the referring physician may claim on the basis of supportive care as outlined in the Schedule.

35. **Assistants' Services:**

(a) Time units are computed by allowing one unit ($6.98) for each 15 minutes or part thereof of time (up to two hours) spent by the assistant. Time units for assistants' services for periods in excess of two hours per case are computed by allowing two units for each 15 minutes or part thereof. Time for purposes of these calculations includes scrub time and time spent in the operating room. If claims are being made in coded form (see Preamble, part B, paragraph 16), the suffix B should be added to the code for the procedure.

(b) The basic units should be listed separately from the time units on the claim card. Benefits for assistants' services are determined by multiplying the listed basic units and the time units by $6.98. For **all** cases commencing after 5:00 p.m. and before midnight or on **all** Saturdays, Sundays and Holidays, the total benefit for assistant units (basic and time) is increased by 30% **(E400B)**. For **all** cases commencing after midnight and before 7:00 a.m., the total benefit for assistant units is increased by **50% (E401B)**.

(c) **When a physician is required to make a special visit to the hospital to assist at surgery, he may charge a special visit premium (C998B) $3.60 for a case commencing after 5:00 p.m. and before midnight or on Saturdays, Sundays or Holidays; (C999B) $7.15 for a case commencing after midnight and before 7:00 a.m. any night of the week. These premiums are in addition to E400B and E401B premiums but apply only to the first patient treated on each special visit.**

(d) When multiple or bilateral surgical procedures are done during the same anaesthetic, the assistant's benefits shall be based on the basic units for the major procedure plus time. When bilateral procedures or surgical revisions are carried out at separate times with separate anaesthetics, the assistant shall be entitled to receive full assistant's benefits for each procedure.

(e) In surgical procedures requiring more than one assistant, benefits for the second assistant shall be computed on the same basis as for the first assistant.
Each claim for second assistant should be accompanied by a statement from the operating surgeon confirming the necessity for his/her services.

(f) When a surgeon requires an assistant at a procedure for which no assistant's units are listed, the assistant may calculate the total benefits applicable by taking the number of basic units used by the anaesthetist, adding his time units and multiplying the total number of units by $6.98. (See also (g) below.)

(g) When assistants at surgery claim for procedures for which no assistants' units have actually been listed in the Schedule, the assistants should support their claims with **a statement of explanation from the surgeon, confirming the medical necessity** for their attendance.

(h) Where the attendance of a physician is requested by the patient's other medical attendants for the sole purpose of monitoring or special supportive care, and when the physician is in constant attendance, the benefits shall be based upon 3 units plus time **(E003B).**

(i) When an anaesthetic has begun and the operation is cancelled prior to commencement of surgery, the assistant who has scrubbed but is not required to do more, should claim 3 basic units plus time units **(E006B).** If the operation is cancelled after surgery has commenced, the procedural basic unit plus time units will apply. If the procedure is cancelled prior to the induction of anaesthesia and the assistant is scrubbed, a subsequent hosptial visit only may be claimed.

36. **Anaesthetists' Services:**

(a) Benefits for anaesthetists' services are for all types of anaesthesia. The rates listed are for professional services, including pre-anaesthetic evaluation and post-anaesthetic follow-up and all immediate supportive measures, and does not include the cost of materials used. If an anaesthetist is asked by a physician to see a registered bed patient in consultation more than 36 hours prior to the administration of an anaesthetic, he may claim for a consultation as well as for rendering the anaesthetic. (This consultation is not a substitute for the pre-anaesthetic evaluation.) If an anaesthetist examines a patient prior to surgery and the surgery is cancelled prior to the induction of anaesthesia, he may claim a subsequent hospital visit for this service. When an anaesthetic has begun and the operation is cancelled due to a complication prior to the commencement of surgery, the anaesthetist should claim 4 basic units plus time (**E006C**). If the operation is cancelled after surgery has commenced, the procedural basic units plus time units will apply.

(b) Basic units are listed for most procedures and include the value of all anaesthetic services except the actual time spent administering the anaesthesia, any modifying factors, or unusual detention with the patient (see paragraph 24, 36(l) below).

(c) Except during maintenance of continuous conduction anaesthesia (G247 pg 100, P015 pg 109), time units are computed by allowing one unit for each 15 minutes or part thereof of anaesthesia time (up to two hours). Following the first two hours of anaesthesia, time units for periods in excess of two hours are computed by allowing two units for each 15 minutes or part thereof. Anaesthesia time begins when the anaesthetist is first in attendance with the patient for the purposes of creating the anaesthetic state and ends when he is no longer in personal attendance (when the patient may be safely placed under customary post-operative supervision).

(d) Time units and listed basic units should be indicated separately on the claim card. Benefits for anaesthetists' services are determined by multiplying the basic and the time units by $7.94 for certified anaesthetists and $7.33 for non-certified anaesthetists. For cases commencing after 5:00 p.m. and before midnight or before midnight on Saturdays, Sundays and Holidays, the total benefit for anaesthetic units (basic and time) is increased by 30% (**E400C**). For cases commencing after midnight and before 7:00 a.m., the total benefit for anaesthetic units is increased by 50% (**E401C**).

(e) **When a physician is required to make a special visit to the hospital to administer an anaesthetic, he may charge a special visit premium of $3.60 (C998C) for a case commencing after 5:00 p.m. and before midnight or on Saturdays, Sundays and Holidays, or $7.15 (C999C) for a case commencing after midnight and before 7:00 a.m. any night of the week. These premiums are in addition to E400C and E401C premiums, but only apply to the first patient treated on each special visit.**

If claims are being made in coded form (see Preamble, part B, paragraph 16) the suffix C should be added to the code for the procedure.

(f) In special cases where the anaesthetic services of more than one anaesthetist are deemed necessary in the interest of the patient the benefits shall be increased by 50% of that computed for the procedure; each anaesthetist to be entitled to one half of the total benefit.

(g) When multiple or bilateral surgical procedures are done during the same anaesthetic, the anaesthetic benefits shall be based upon the basic units for the major procedure plus time. When bilateral procedures or surgical revisions are carried out at separate times with separate anaesthetics, the anaesthetist shall be entitled to receive full anaesthetic benefits for each procedure.

(h) In procedures where no units are listed or with I.C., the basic units will be based upon those listed for a comparable procedure considering region and modifying conditions or techniques.

PREAMBLE

(i) When a pump with or without an oxygenator and with or without hypothermia is employed in conjunction with an anaesthetic, the anaesthetic "Basic" will be 28 units; this replaces the listed basic units for the procedure. To compensate for variations in anaesthetic practice, special respiratory intensive care or detention for the purpose of intensive treatment of other types may be claimed separately under the appropriate headings.

(j) An additional 10 units may be claimed when, in association with anaesthesia, "controlled hypotension" is carried out using any technique to deliberately lower and maintain the mean blood pressure at least 25% below the range or normal for that patient. The extra 10 units may be claimed under code **E004C.**

(k) When unusual detention with the patient before or after anaesthesia is essential for the safety and welfare of such patient, the necessary time will be valued on the same basis as indicated for the anaesthetic time.

(l) For detention not associated with anaesthesia detention rates and criteria apply (see paragraph 24 above).

(m) When the attendance of the anaesthetist is requested by the patient's other medical attendants for the purpose of monitoring or special supportive care, and when the anaesthetist is in constant attendance the benefits shall be based upon 3 units plus time. If claims are coded, the code is **E003C.**

(n) No additional claim should be made for introducing a catheter for continuous conduction anaesthesia, i.e. above the basic of 5 units plus **hospital visits rendered for maintenance and supervision (to a maximum of four hospital visits)** plus the number of time units required for the **final** delivery.
When hospital visit(s) is rendered for maintenance and/or supervision of continuous conduction anaesthesia or analgaesia (after 5 p.m. but before midnight) an additional 30% (E402A) may be claimed with that visit (P015A or G247). When a maintenance and/or supervision visit occurs after midnight and before 7 a.m. an additional 50% may be claimed (E403A) with P015A or G247.

(o) When a physician administers an anaesthetic and/or other medication prior to or during a procedure(s) and also performs a procedure(s) on the same patient, he should claim for the procedure(s) only. However, when a physician administers a pudendal, femoral, intercostal, sciatic, ilioinguinal or iliohypogastric block in addition to performing a procedure, he may charge $7.15 **(G224)** in addition to the fee for the procedure.

(p) When hypothermia is used by the anaesthetist in procedures not specifically identified as requiring hypothermia, the basic value is 25 units. This basic value replaces the basic value listed in the Schedule for the procedure. When the basic value claimed is 25 units, the anaesthetic service may be claimed under code **E002C**.

(q) When one anaesthetist starts a procedure and is replaced by another part way through a surgical procedure or delivery, the first anaesthetist should claim the appropriate basic units plus time units and the second anaesthetist may claim for time units only. The second anaesthetist should use code **E005C** for such time units except in the case of continuous conduction anaesthesia; **in the latter case, hospital visits apply (see para 36(n)).**

E005C qualifies for the surcharge E400C or E401C only if the case originally started within the time stated under paragraph 36(f) above. Each anaesthetist should state on his claim card which part of the anaesthetic is being claimed and the time begun and completed.

(r) General anaesthesia for the purposes of this Schedule includes all forms of anaesthesia except local infiltration.

PREAMBLE

APPENDIX A

Sections 53 and 54 of Ontario Regulation **452 of Revised Regulations of Ontario 1980** made under the Health Insurance Act.

"(1) The following services are not insured services under the Plan:

— Except where medically required, surgery for cosmetic purposes.

— Expenses for travelling time or mileage.

— Testimony in a court, preparation of records, reports, certificates or communications.

— Advice by telephone.

— Any service or examination for the purpose of,

(a) an application for insurance or under a requirement for keeping insurance in force:

(b) an application for admission to or continuance at or in a school, college, university, camp, association, club, group or program:

(c) employment or the continuance of employment or pursuant to the request of an employer or other person in authority:

— Group examinations, immunizations or inoculations.

— Any service or examination rendered by a physician for screening, survey or research purposes.

— Services rendered by a physician pursuant to an arrangement for rendering services.

(a) to the employees of an employer;

(b) to members of an association; or

(c) at a camp to the campers thereof.

— Laboratory services, except,

(a) laboratory services prescribed in section 48a, and

(b) Laboratory services carried out by a physician for the exclusive purpose of diagnosing or treating his own patients in the course of his medical practice.

— Special appliances.

— Clinical pathology, except when authorized by a physician and performed.

(a) by a laboratory mentioned in clause **52 (1)(a) or (b); or**

(b) by or under the direction of any other person authorized by law.

— All procedures of acupuncture.

(2) The following services rendered by physicians shall be deemed not to be insured services for the purposes of the Act:

— Anaesthetic services rendered in connection with a dental procedure rendered by a dentist except where the dental procedure is performed in a hospital.

APPENDIX A - Cont'd

- Pre-adoption examination and evaluation for C.A.S.
- Other scan (approved but not currently listed).
- Preparation of special antigens or anti-serums.
- Special investigations.
- Dermatoglyphics.
- Group psychotherapy — seventh to ninth hour per day.
- Psychotherapy — interviews with other paramedical organizations or others on behalf of a patient.
- Orthoptics.
- Contact lens fitting, except for any of the following conditions:
  (a) Aphakia, monocular and binocular;
  (b) High Myopia, greater than nine diopters;
  (c) Irregular astigmatism (post-corneal grafting or corneal scarring resulting from disease states);
  (d) Keratoconus.
- Non-referred mammography or thermography.
- The use of EDTA in the treatment of atherosclerosis.
- HCG treatment for obesity.
- General assessment for nicotine addiction or obesity where treatment is to be by acupuncture or ear pins.

54. The following service rendered by a physician shall be deemed not to be an insured service in respect of an insured person who is eighteen years of age or over:

1. Otoplasty for correction of "outstanding ears."

55(1) The following services rendered outside of Ontario by physicians shall be deemed not to be insured services in respect of insured persons who are under the age of sixteen years:

1. Ligation, cauterization or removal of vas deferens—uni or bilateral (vasectomy).

2. Hysterectomy or ligation, cauterization or removal of fallopian tubes—uni or bilateral by abdominal or vaginal approach, including laparoscopy, culdoscopy, or hysteroscopy—for sterilization (any method).

(2) All services rendered outside of Ontario by hospitals in connection with the services specified in subsection 1 shall be deemed not to be insured services in respect of insured persons who are under the age of sixteen years.

(3) Subsections 1 and 2 do not apply where the surgeon or the attending physician believes that the surgical operation is medically necessary for the protection of the physicial health of the insured person.

PREAMBLE

APPENDIX A – Cont'd

55a(2)-1. Any service or examination for the purpose of legal requirements or proceedings, other than an examination rendered by a psychiatrist, who is not a member of the medical staff of a psychiatric facility in which a patient is detained, for the purpose of clause 35(4)(*b*) of the *Mental Health Act*.

PREAMBLE

APPENDIX B

Section 29 of Regulation **448 of Revised Regulations of Ontario, 1980 under the** Health Disciplines Act.

29—(1) A member shall,

- (a) keep a legibly written record in respect of each patient of the member setting **out,**
  - (i) the name and address of the patient,
  - (ii) each date that the member sees the patient,
  - (iii) a history of the patient,
  - (iv) particulars of each physical examination of the patient by the member,
  - (v) investigations ordered by the member and the results of the investigations,
  - (vi) each diagnosis made by the member respecting the patient, and
  - (vii) each treatment prescribed by the member for the patient;
- (b) keep a day book, daily diary or appointment record setting out the name of each patient seen or treated or in respect of whom a professional service is rendered by the member.

(2) A member shall keep the records required under subsection (1) in a systematic manner and shall retain each record for a period of six years after the date of the last entry in the record or until the member ceases to engage in the practice of medicine, whichever first occurs.

(3) A member shall make records kept pursuant to subsection 1 and books, records, documents and things relevant thereto available at reasonable hours for inspection by a person appointed by the Registrar pursuant to section 64 of the Act, a member appointed by the Registrar for the purpose of peer review or a person appointed as an inspector under section 43(1) of the Health Insurance Act.

PREAMBLE

APPENDIX C

"EMERGENCY DEPARTMENT" CLAIMS

PHYSICIAN ON DUTY

The listings under the heading "Emergency Department—Physician on Duty" are meant to apply only to those circumstances wherein either **emergency** or other physicians have elected **or** are required to be physically and continuously present in the Emergency Department or environs for an arranged designated period of time.

When the Physician on Duty is required or elects to remain at the hospital, the special call surcharge will not apply. Use the "Emergency Department — Physician on Duty" listings for all physicians regardless of specialty.

When **an emergency physician** is required to make a special visit to the Emergency Department prior to or after his regular arranged designated period of time on duty, he may claim the appropriate benefit under the General Listings plus the applicable special visit premium for the first patient assessed; all subsequent patients assessed during this visit to the hospital should be claimed under the Emergency Department—Physician on Duty listings.

When a physician is on duty in the Emergency Department, sees a patient and admits the patient to hospital, this physician may claim a minor or multiple systems assessment depending upon the service initially provided. Either the patient's attending physician or the emergency department physician (but not both) may render and claim the hospital "admission assessment". If the emergency department physician instead of the attending physician provides the admission general assessment, he may claim a general re-assessment (**C004**) as well as the initial assessment provided that both services are rendered separately.

SPECIAL VISIT TO EMERGENCY OR O.P.D.

Consultation

1. Consultation, patient not admitted:
   The benefit for the consultation (or repeat consultation) plus the appropriate special visit surcharge (K99-) may be claimed.
2. Consultation, patient admitted:
   (a) The benefit for the consultation (or repeat consultation) plus the appropriate special visit surcharge (K99-) followed by hospital visits (if rendered) may be claimed. However, if the consultant also is the "most responsible physician", he may not also claim a hospital in-patient consultation, repeat consultation, general or specific assessment, general or specific reassessment since the initial consultation rendered in the emergency department serves as the admission assessment.

   (b) If the consultant is not also the most responsible physician, the latter may claim the appropriate admission assessment.

PREAMBLE

APPENDIX C - Cont'd

Assessment:

1. Assessment, patient not admitted —
   The benefit for the assessment (or re-assessment) plus the appropriate special visit surcharge (K99-) may be claimed.

2. General/specific assessment plus patient admission —
   The benefit for the general or specific assessment plus the appropriate special visit surcharge (K99-) followed by hospital visits may be claimed. However, the admitting physician may not also claim a hospital in-patient general/specific assessment or reassessment since the initial general/specific assessment rendered in the emergency department serves as the admission.

3. Minor/intermediate assessment plus patient admission —
   The benefit for the minor or intermediate assessment plus the appropriate special visit surcharge (K99-) may be claimed. In addition, the admitting physician may claim for a hospital in-patient general or specific reassessment if rendered.

Procedure:

Except for procedures for which the listed benefits specifically include the associated consultation or other assessment, claims may be made for both the procedure and the assessment.

Note:

If a physician has an office in the hospital and is called to assess a patient in the Emergency Department or O.P.D., the special visit premiums do not apply.

PREAMBLE

APPENDIX D

1. Surgery to alleviate significant physical symptoms or to restore or improve function to any area altered by disease, trauma or congenital deformity normally is a benefit under The Ontario Health Insurance Plan. Surgery solely to alter or restore appearance is not a benefit of OHIP except under the circumstances as listed in the following policy.

2. Emotional, psychological or psychiatric grounds are not considered sufficient reason for OHIP coverage of surgery for alteration of appearance except under exceptional circumstances. On request of the attending physician, exceptions may be made on an independent consideration basis if the proposed surgery is to alter a significant defect in appearance caused by disease, trauma or congenital deformity, *and* if the surgery is

   —recommended by a Mental Health Facility (as designated by The Mental Hospitals Act) or equivalent, or

   —recommended by a Correctional Institution, or

   —essential in order to obtain employment as documented by the attending physician *and* either by a Canada Manpower Employment Centre or by an employer with regard to a specific job, or

   —performed on a patient who is less than 18 years of age and the defect is in area of the body which normally and usually would not be clothed.

3. In establishing this policy, it has been recognized that

   —peer acceptance in our society often is influenced disproportionately by the facies,

   —children are especially susceptible to emotional trauma caused by physical appearances,

   —some procedures traditionally have been accepted as benefits of Health Insurance Plans inspite of the obvious cosmetic nature of these procedures.

4. Surgery to revise or remove features of physical appearance which are familial in nature is not a benefit of OHIP.

5. Within the context of this policy, the word "disease" does not include the normal sequelae of aging. Surgery to alter changes in appearance caused by aging is not a benefit of OHIP.

6. Within the context of this policy, the word "trauma" includes trauma due to treatment such as surgery, radiation, etc.

7. The phrase "reasonable period of convalescence" admittedly is imprecise, but it does not seem reasonable to set a definite time interval of convalescence following each procedure. Independent consideration will be given to the questionable cases.

8. Authorization from OHIP is not required for all surgery to alter appearance. It is required only for those categories of procedures for which some cases may not be a benefit under OHIP policy.

PREAMBLE

APPENDIX D - Cont'd

Surface Pathology

1. **Trauma Scars**

   (a) Neck or Face

   —Includes ears and non-hair bearing areas of the scalp.

   —Repair of all such scars is a benefit of OHIP.

   —Repair procedures will depend upon the lesion but may include excision, revision, dermabrasion, etc. Rhytidectomy procedures to remove scar prominence, however, are not a benefit of OHIP.

   —OHIP authorization for repair of such scars is not required but manual assessment of the claims will be necessary to ensure that the most appropriate procedure codes are used.

   (b) Scars in other Anatomical Areas

   —Repair of scars which interfere with function or which are significantly symptomatic (pain, local irritation, etc.) is a benefit of OHIP.

   —Scars with no significant symptoms or functional interference

   (i) Repair is a benefit if such repair is part of a pre-planned post-traumatic (including post-surgical) staged process. OHIP notification must be included as part of the planning process.

   (ii) Other post-traumatic scar revision is not a benefit of OHIP.

   —OHIP authorization is required for all scar repair procedures in areas other than the face or neck.

2. **Keloids**

   (a) Head or Neck

   —The repair of all such keloids is a benefit of OHIP.

   —Repair procedures may include excision and/or injection.

   —Although no pre-authorization is needed, claims for excision of keloids are assessed manually to ensure that the most appropriate code is used.

   (b) Excision of keloids in other areas

   —Not a benefit of OHIP unless significantly symptomatic or there is functional impairment.

   —OHIP authorization is required.

3. **Tattoos**

   (a) Face or Neck

   —Excision or destruction of all such tattoos is a benefit of OHIP.

   —Authorization is not required but adjudication of repair procedures will be identical to that for scars in these areas.

   (b) Other Anatomical Areas

   —Excision or destruction of concentration camp or P.O.W. tattoos is a benefit of OHIP. Otherwise, normally not a benefit of OHIP.

PREAMBLE

APPENDIX D - Cont'd

4. **Benign lesions such as naevi, keratoses, spider naevi, papillomata, neurofibromata**

   (a) Face or Neck

   —Excision or destruction of these lesions is a benefit of OHIP.

   —Authorization is not required.

   (b) Other Anatomical Areas

   —Normally not a benefit of OHIP if removed for alteration of appearance, only, rather than for medical necessity or because of clinical suspicion or evidence of malignancy.

   —Removal of very large lesions in patients less than 18 years of age is a benefit of OHIP.

   —Authorization is not required but a statement of the reason for removal must accompany the claim.

5. **Hair Loss**

   (a) Head or Neck

   (i) Patients less than 18 years of age

   —Repair is a benefit for non-hereditary etiologies.

   —Authorization is not required. However, if it is possible that a planned staged procedure will extend beyond the age limit, pre-authorization should be obtained, since it will be necessary after the 18th birthday.

   (ii) Post-traumatic

   —Repair to the area of traumatic hair loss is a benefit of OHIP only if carried out within a reasonable period of convalescence.

   —OHIP authorization is required.

   (iii) Other Etiology

   —Not a benefit of OHIP.

   (iv) Usual repair procedures may include skin shifts or flaps, skin grafts, or hair plugs.

   (b) Other Anatomical Areas

   —Not a benefit of OHIP.

6. **Epilation of Hair**

   (a) Face

   —This procedure is a benefit of OHIP only for those patients with documented endocrine abnormality or drug-induced hirsuitism.

   (b) Other Anatomical Areas

   —Not a benefit of OHIP.

   (c) —OHIP authorization is required.

PREAMBLE

APPENDIX D - Cont'd

7. **Redundant Skin**
   - (a) Excision of redundant skin for elimination of wrinkles, etc. is not a benefit of OHIP.
   - (b) Blepharoplasty is not a benefit of OHIP unless there is documented evidence of medical necessity such as visual field defect caused by the redundant eyelid skin.
   - (c) OHIP authorization is required.

Sub-Surface Pathology

1. **Congenital deformities**
   - (a) Head or Neck
     - —Repair is a benefit of OHIP except for:
       - —surgery to revise or remove features which are familial in nature.
       - —surgery to correct "outstanding ears" in patients who are eighteen years of age or over.
     - —Authorization is not required but manual assessment of the claims will be necessary to ensure that the most appropriate procedural codes are used.
   - (b) Other Anatomical Areas
     - —Normally not a benefit of OHIP if surgery is for alteration of appearance only.
2. **Post-Traumatic Deformities**
   - —Reconstructive procedures are a benefit at the acute stage; within a reasonable period of convalescence; or if part of a pre-planned staged process of repair.
   - —Repair of procedures may include bone revision, tissue shifts and grafts, prosthesis implantation, etc.
   - —OHIP authorization is required for repairs beyond the acute stage.
3. **Deformities resulting from local disease**
   (such as loss or distortion of bone, muscle, connective tissue, adipose tissue, etc.)
   - (a) Head or Neck
     - —Reconstructive procedures for significant abnormalities are a benefit at the acute stage; during a chronic disease process; within a reasonable period of convalescence; or if part of a planned staged process of repair initiated during one of these periods.
     - —Repair procedures normally could include tissue grafts, flaps or shifts, bone revision, prosthesis insertion, etc.
     - —Face lifts, modified face lifts, brow lifts, etc. are not a benefit of the Plan if skin, only, is involved in the procedure. However, a repair such as ptosis repair or face lift with underlying slings is a benefit of OHIP if the procedure is to correct significant deformity following stroke, cancer, VIIth nerve palsy, etc.
     - —OHIP authorization is required for repair of deformities resulting from local disease.

APPENDIX D - Cont'd

(b) Other Anatomical Areas

—Not a benefit of OHIP if the correction is for appearance, only.

4. **Breast Surgery**

(a) Augmentation Mammoplasty

—This procedure is a benefit of OHIP unilaterally or bilaterally for a female patient with breast aplasia.

—It is an OHIP benefit unilaterally for a female patient with a severely hypoplastic breast when the other breast is not also hypoplastic.

—A "balancing" augmentation mammoplasty may be allowed on an independent consideration basis for correction of unilateral hypoplasia when performed in association with approved contralateral reduction mammoplasty.

—The correct code for the repair procedure is R112.

—OHIP authorization is required.

(b) Post-Mastectomy Reconstruction

—Unilateral or bilateral breast reconstruction is a benefit of OHIP when the procedure is subsequent to, as listed in the Schedule of Benefits, total or partial mastectomy (including wedge resection) or prophylactic mastectomy.

—Authorization is not required but all claims are manually assessed to determine the benefit appropriate to the procedure rendered.

(c) Reduction Mammoplasty

—**Reduction Mammoplasty** is a benefit for female patients only, where there is significant associated symptomatology such as intertrigo, neck or back pain or shoulder grooving. Ptosis and/or size are not sufficient grounds for OHIP coverage of reduction mammoplasty

—Unilateral Reduction Mammoplasty may be a benefit of the Plan if there is gross disproportion present, or in association with approved unilateral augmentation mammoplasty or post mastectomy reconstruction of the contralateral breast.

—OHIP authorization is required.

(d) Male Mastectomy

—This procedure is a benefit of the Plan.

—The appropriate code for the procedure is R115 or R116.

—Authorization is not required.

(e) Accessory breasts or accessory nipples

—Excision of such accessory tissue is a benefit of the Plan.

—The appropriate code should be used from the Schedule listings under Skin and Subcutaneuous tissue.

—Authorization is not required.

APPENDIX D – Cont'd

5. **Excision of excess fatty tissue**

—This is a benefit of the Plan only if there is significant associated symptomatology such as intertrigo, pain or excoriations.

—When performed for alteration of appearance, the removal of redundant skin and fat, from the abdomen, extremities, etc. is not a benefit of the Plan.

—OHIP authorization is required.

Sex-Reassignment Surgery

(1) Sex-reassignment surgical procedures are a benefit of OHIP only if they are performed on patients who have completed the Gender Identity Clinic program operated by the Clarke Institute of Psychiatry in Toronto. Moreover, claims are accepted for payment only for those patients for whom the Clinic has recommended that surgery take place. This surgery need not take place in Toronto or even in Ontario. Surgery recommended by the Clinic which takes place outside the Province of Ontario may be approved for payment at rates in accordance with the current OHIP Schedule of Benefits.

(2) Within the foregoing guidelines, reconstruction of genitalia and mastectomy are benefits of the Plan. However, since the hormonal treatments associated with sex-reassignment themselves give rise to breast enlargement, augmentation mammoplasty or breast reconstruction in a male to female conversion normally would not be a benefit of OHIP, in keeping with the previously outlined policy regarding breast surgery in females.

(3) OHIP authorization is required.

Complications and/or Revisions

(1) The treatment of acute medical or surgical complications resulting from surgery for alteration of appearance and/or function is a benefit of the Plan whether or not the original surgery was covered by OHIP. This includes complications resulting from trans-sexual surgery (such as breakdown of the artificial vaginal wall). No authorization is required.

(2) Revision of surgery for alteration of appearance, because of undesirable results, is a benefit of the Plan if the original surgery was a benefit *and* if the revision either is part of a pre-planned staged process or occurs within a reasonable period of convalescence. Correction of the effects on appearance which are due to complications, is a benefit of the Plan if it is carried out within a reasonable period of convalescence. OHIP authorization is required only if the original surgical procedure, if it had been carried out at the time of the proposed revision, would have required such authorization. For example, authorization would not be required for revision in a 16-year-old of a repaired congenital ear deformity. However, if the child is 18 years or older at the time of the revision, authorization would be required.

PREAMBLE

APPENDIX E

REGULATIONS FOR EMPLOYMENT OF A LOCUM TENENS

A Locum Tenens

(a) Must replace the employing physician, who must be absent from the practice.

(b) Must replace the employing physician for a continuous period up to a maximum of 12 weeks, with an extension on request for a further 6 weeks.

(c) Must be the same specialty as the employing physician.

(d) Must be licensed by the College of Physicians and Surgeons of Ontario in a category of licence that allows him or her to practice independently without supervision.

Prior notification must be given to OHIP of the name and OHIP physician number and/or licence number of the locum tenens and the exact dates of employment, together with an authorization from the locum tenens to make payment for his or her services to the employer.

If these conditions are met, the locum tenens may sign the employing physician's claim cards.

If any of the above conditions are **not** met, the physician involved must submit claims to OHIP on his or her own claim cards.

CONSULTATIONS AND VISITS

Code	FAMILY PRACTICE AND PRACTICE IN GENERAL (00)	$
	General Listings:	
	(Use these listings when performed at locations other than those designated in the following sections)	
A005	Consultation	37.20
A006	Repeat consultation	28.30
A003	General assessment	34.30
A004	General re-assessment	20.00
A903	Pre-dental general assessment	30.05
A007	Intermediate assessment/**Well Baby Care**	16.10
A001	Minor assessment	11.80
K017	Annual Health Examination — child (after 2nd birthday)	20.70
K009	— adolescent, adult	30.05
A009	Oculo-visual assessment (including refraction and tonometry)	27.50
N.C.	Telephone advice including renewal of prescription	N.A.B.
N.C.	Dispensing service fee	N.A.B.
	Non-emergency Hospital In-patient Services	
Note:	For emergency calls and other visits to hospital in-patients for which "special visit" premiums apply, use General Listings and refer to Preamble, Part B, paragraph **23**. (If physician already in hospital, refer to paragraph **18**(d))	
C005	Consultation	37.20
C006	Repeat consultation	28.30
C003	General assessment	34.30
C004	General re-assessment	20.00
C903	Pre-dental general assessment	30.05
	Subsequent visits (minor assessments):	
C002	up to five weeks per visit	10.70
C007	from sixth to thirteenth week inclusive (not to exceed $32.10 per week) per visit	10.70
C009	after thirteenth week (not to exceed $64.20 per month) per visit	10.70
C008	Concurrent care (minor assessments) (See Preamble) per visit	10.70
C010	Supportive care (minor assessments): See definition in Preamble. The physician may claim for this care on a per visit basis (not to exceed four such visits during the first week and not to exceed two such visits each week thereafter) per visit	8.90
Note:	If medical complications develop or are present in the post-operative period, hospital medical care may be claimed rather than supportive post-operative care. Such claims should be substantiated by the physician.	
H007	Attendance at maternal delivery for care of a high risk baby(s) — (if only service rendered at time of delivery)	42.90
Note:	Consultation should not be claimed with attendance at maternal delivery. — other fees may apply.	

CONSULTATIONS AND VISITS

Code	FAMILY PRACTICE AND PRACTICE IN GENERAL - Cont'd	$
H001	Newborn care in hospital and/or home	36.80
H002	Low birth weight baby care (uncomplicated) initial visit (per baby)	22.90
H003	— thereafter per visit	11.80
	Emergency Department — Physician on Duty:	
Note:	A physician on duty in Emergency, called to see a hospital bed patient because of acute complications may not claim special visit surcharges. **See Preamble, Part B, paragraph 18(d)**	
H103	Multiple systems assessment — **includes** interpretation of x-ray, E.C.G. and other laboratory data **as required**	18.60
H101	Minor assessment — no additional benefit for interpretation of x-ray, E.C.G. and other laboratory data	9.50
	When above visits are rendered by the physician on duty in premium hours, apply one of the following premiums per patient visit to H101 or H103.	
H110	— **12 midnight to 8:00 a.m. — 50%** of (H103 or H101)	
H106	— **Saturdays, Sundays or Holidays — 20%** of (H103 or H101)	
	Where no assessment fee (H101, H103) is chargeable, the premium to be added to the procedure(s) per patient visit is one of the following:	
H112	— **12 midnight to 8:00 a.m.**	9.30
H113	— **Saturdays, Sundays or holidays**	3.70
	Emergency or O.P.D. — Physician in Hospital But Not on Duty in the Emergency Department When Seeing Patient(s) in Emergency or O.P.D.: (Use General Listings)	
	Long Term Institutional Care:	
Note:	For emergency calls and other visits to institutional patients for which "special visit" premiums would apply, use General Listings and refer to Preamble, Part B, paragraph **23**. (If physician already in Institution refer to paragraphs **20, 21**.)	
	1. Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, or other Institutions in which patients are covered by extended care legislation:	
W105	Consultation	37.20
W106	Repeat consultation	28.30
	Admission assessment (see Preamble)	
W102	Type 1	34.30
W104	2	11.80
W109	Annual physical examination	30.05
W004	General re-assessment of patient in nursing home or covered by extended care legislation	11.80
Note:	May only be claimed 6 months after Annual Health Examination (as per the Nursing Homes Act.)	
W903	Pre-dental **or Pre-Surgical** general assessment	30.05

CONSULTATIONS AND VISITS

Code	**FAMILY PRACTICE AND PRACTICE IN GENERAL – Cont'd**	$
	Subsequent visits (minor assessments — **See preamble, Part B, paragraphs 20, 21)**	
	— chronic care or convalescent hospital (maximum of 10 per patient, per month)	
W002	— first two visits per month (chargeable by most responsible physician) . . . . per visit	10.70
W001	— subsequent visits per month . . . . per visit	7.50
	— nursing home or other institution covered by extended care legislation (maximum of 5 per patient, per month)	
W003	— first visit per month (chargeable by most responsible physician) . . . . per visit	10.70
W008	— subsequent visits per month . . . . per visit	7.50
	2. Homes for the Aged, and other Institutions in which patients are Not Covered by Extended Care Legislation: (Use General Listings)	
Note:	General Listings under these circumstances also apply to patients seen in bed rather than in an office supplied by the institution.	
	Psychotherapy: (includes narcoanalysis, psychoanalysis or treatment of sexual dysfunction) (See Preamble, part B, paragraph 12)	
K007	Individual — per ½ hour or major part thereof (see Preamble)	32.20
	Group — (four to eight people) per ½ hour or major part thereof	
K012	— per member (up to six hours per day)	6.00
N.C.	— per member (more than 6 hours per day)	N.A.B.
K004	Family — (two or more family members in attendance at the same time) per ½ hour or major part thereof	36.50
	Hypnotherapy:	
K006	Individual — per ½ hour or major part thereof	32.20
Note:	May not be claimed with diagnosis of acne, psoriasis, smoking, obesity or in conjunction with delivery.	
K011	Group, for induction and training for hypnosis (up to eight people) per ½ hour or major part thereof per member — (not applicable to prenatal patients)	6.00
K013	**Counselling**—intended as an educational experience — not intended for ongoing therapy or as a substitute for a patient assessment (see Preamble, part B, paragraph 13) — one or more people per ½ hour or major part thereof	30.80

Code	**FAMILY PRACTICE AND PRACTICE IN GENERAL – Cont'd**	$
	Genetic Counselling: (See Preamble, Part B, paragraph 14)	
K019	Individual or family, per ½ hour (maximum 2 hours)	36.50
K020	Interview with relatives, per ½ hour (maximum 2 hours)	36.50
Note:	1.) Psychotherapy or hypnotherapy or counselling is not to be claimed in conjunction with other consultations or assessments rendered by the same physician during the same patient visit unless there are clearly defined unrelated diagnoses for the two services. 2.) The minimum time period for psychotherapy (to be claimed as such) is 20 minutes. (See Preamble, part B, paragraph **12**.) 3.) Advice given during a visit for patient assessment and relative to that assessment (see definitions) is included in the assessment benefit and does not qualify for "counselling".	
	Certification of Mental Illness	
K623	**Application for psychiatric assessment, (as mandated by the Mental Health** Act) — including necessary history, examination and completion of form	50.10
K624	Certification and re-certification of involuntary admission (as required by the Mental Health Act at not more than 120 hours and 2 weeks) — to include history, examination and completion of form per ½ hour or major part thereof	36.20
K629	All other re-certification(s) of involuntary admission	19.30
Note:	Consultation or assessment normally may not be claimed in addition.	
N.C.	**Certification of incompetence, including assessment to determine incompetence**	N.A.B.
	Interviews:	
K002	Interviews with relatives on behalf of a patient, per ½ hour or major part thereof	30.80
K003	Interviews with C.A.S. or legal guardian on behalf of a patient, per ½ hour or major part thereof	30.80
Note:	K002, K003 — Should be claimed on the patient's claim card with diagnosis. These listings apply to situations where medically necessary information cannot be obtained from or given to the patient (e.g. because of illness, incompetence, etc).	
	Diagnostic interview and/or counselling with child and/or parent:	
K008	for psychological problem or learning disabilities per ½ hour	32.20
Note:	Claims for K008 should be submitted on child's card.	
N.C.	for testing per ½ hour	N.A.B.
N.C.	Interviews with other paramedical organization or others on behalf of a patient, per ½ hour or major part thereof	N.A.B.
N.C.	Case conference — with medical and/or paramedical personnel on behalf of a patient, per ½ hour or major part thereof	N.A.B.

Code	FAMILY PRACTICE AND PRACTICE IN GENERAL – Cont'd	$
	Certification and Reports:	
	With or Without Examination	
N.C.	Certification of health (ordinary), disability, or immunization status	N.A.B.
N.C.	Free from infection (barbers, waiters, etc.)	N.A.B.
N.C.	Insurance report based on previous examination	N.A.B.
N.C.	Insurance report on illness or death	N.A.B.
N.C.	Medico-legal reports	N.A.B.
	Sexual Assault Investigation	
	Examination and documentation for investigation and/or confirmation of alleged sexual assault	
K018	—female	185.00*
K021	—male	145.00*
*	A portion of the listed benefits for K018 and K021 is recovered by OHIP from the Ministries of the Attorney General and the Solicitor General.	
	Premiums for Special Visits; I.C.U., C.C.U.; Detention:	
	(See Preamble, Part B, paragraphs **23**, **24**.)	

ALLERGY (39)

Since the Royal College of Physicians and Surgeons of Canada has not set a standard for "Allergy Specialist", benefits for consultations and visits shall be applicable to a special allergist as they refer to him in his own General or Specialty Section except for the following:

Code	Description	$
K399	Clinical interpretation by immunologists where a report of a survey is submitted in writing to the patient's physician (not to apply when the immunologist claims for a consultation)	19.10

ANAESTHESIA (01)

General Listings:

(Use these listings when performed at locations other than those designated in the following sections)

Code	Description	$
A015	Consultation	53.70
A016	Repeat consultation	34.30
A013	Specific assessment	30.80
A014	**Partial** assessment	13.60

Emergency or O.P.D. — Physician in Hospital But Not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.:

(Use General Listings)

CONSULTATIONS AND VISITS

Code	ANAESTHESIA – Cont'd	$
	Non-emergency Hospital In-patient Services:	
Note:	For emergency calls and other visits to hospital in-patients for which "special visit" premiums apply, use General Listings and refer to Preamble, Part B, paragraph **23**. (If physician already in hospital, refer to paragraph **18**(d).)	
C015	Consultation (See Preamble-paragraph **36**(a))	53.70
C016	Repeat consultation (See Preamble-paragraph **36** (a))	34.30
C013	Specific assessment	30.80
C014	Specific re-assessment	17.90
	Subsequent visits; (minor assessments)	
C012	up to five weeks per visit	12.20
C017	from sixth to thirteenth week inclusive (not to exceed $36.60 per week) per visit	12.20
C019	after thirteenth week (not to exceed $73.20 per month) per visit	12.20
C018	Concurrent care (minor assessments) per visit	12.20

Premiums for special visits; I.C.U., C.C.U.; Detention:
(See Preamble, Part B, paragraphs **23**, **24**.)

CARDIOLOGY (60)

For services not listed, refer to Internal Medicine Section

General Listings:
(Use these listings when performed at locations other than those designated in the following sections)

Code	Description	$
A605	Consultation	76.55
A645	Limited consultation	50.10
A606	Repeat consultation	50.10
A603	General assessment	41.50
A604	General re-assessment	30.05
A608	**Partial** assessment	16.10

Emergency or O.P.D. — Physician in Hospital But Not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.
(Use General Listings)

Non-emergency Hospital In-patient Services:

Code	Description	$
Note:	For emergency calls and other visits to hospital in-patients for which "special visit" premiums apply, use general listings and refer to Preamble, Part B, paragraph **23**. (If physician already in hospital, refer to paragraph **18**(d).)	
C605	Consultation	76.55
C645	Limited consultation	50.10
C606	Repeat consultation	50.10
C603	General assessment	41.50
C604	General re-assessment	30.05

CONSULTATIONS AND VISITS

Code	CARDIOLOGY – Cont'd	$
	Subsequent visits (minor assessments):	
C602	up to five weeks per visit	12.20
C607	from sixth to thirteenth week inclusive (not to exceed $36.60 per week) per visit	12.20
C609	after thirteenth week (not to exceed $73.20 per month) per visit	12.20
C608	Concurrent care (minor assessments) per visit	12.20

Premiums for special visits; I.C.U.; C.C.U.; Detention:
(See Preamble, Part B, paragraphs **23, 24**)

CARDIOVASCULAR AND THORACIC SURGERY (09)

General Listings:
(Use these listings when performed at locations other than those designated in the following sections)

Code	Service	$
A095	Consultation	38.60
A096	Repeat consultation	30.40
A093	Specific assessment	27.50
A094	**Partial** assessment	13.60

Emergency or O.P.D. — Physician in Hospital But Not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.:
(Use General Listings)

Non-emergency Hospital In-patient Services:

Note: For emergency calls and other visits to hospital in-patients for which "special visit" premiums apply, use General Listings and refer to Preamble, Part B, paragraph **23**. (If physician already in hospital, refer to paragraph **18**(d).)

Code	Service	$
C095	Consultation	38.60
C096	Repeat consultation	30.40
C093	Specific assessment	27.50
C094	Specific re-assessment	16.80
	Subsequent visits (minor assessments):	
C092	up to five weeks per visit	12.20
C097	from sixth to thirteenth week inclusive (not to exceed $36.60 per week) per visit	12.20
C099	after thirteenth week (not to exceed $73.20 per month) per visit	12.20
C098	Concurrent care (minor assessments) per visit	12.20

Long Term Institutional Care — Chronic and Convalescent Hospital, Homes for the Aged — Patients Covered by Extended Care Legislation and Nursing Homes:

Code	Service	$
W095	Consultation	38.60
W096	Repeat consultation	30.40

Premiums for special visits; I.C.U., C.C.U.; Detention:
(See Preamble, Part B, paragraphs **23, 24**)

CONSULTATIONS AND VISITS

Code	CLINICAL BIOCHEMISTRY (30)	$
	General Listings: (use these listings when performed at locations other than those designated in the following sections)	
A305	Consultation	50.10
A306	Repeat or limited consultation	34.30
	Non-emergency Hospital In-patient Services:	
C305	Consultation	50.10
C306	Repeat or limited consultation	34.30
C308	Concurrent care (minor assessments) . . . per visit	12.20
	Outpatient Department:	
H305	Consultation	50.10
H307	Repeat or limited consultation	34.30

Premiums for special visits; I.C.U., C.C.U.; Detention:
(see Preamble, Part B, paragraphs **23**, **24**)

CLINICAL IMMUNOLOGY (62)

For services not listed, refer to Internal Medicine Section.

General Listings:
(use these listings when performed at locations other than those designated in the following sections)

A625	Consultation	76.55
A525	Limited consultation	50.10
A626	Repeat consultation	50.10
A623	General assessment	41.50
A624	General re-assessment	30.05
A628	**Partial** assessment	16.10

Emergency or O.P.D. -- Physician in Hospital But Not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.:
(use General Listings)

Non-emergency Hospital In-patient Services:

Note: For emergency calls and other visits to hospital in-patients for which "special visit" premiums apply, use General Listings and refer to Preamble, Part B, paragraph **23**. (If physician already in hospital, refer to paragraph **18**(d).)

C625	Consultation	76.55
C525	Limited consultation	50.10
C626	Repeat consultation	50.10

CONSULTATIONS AND VISITS

Code	CLINICAL IMMUNOLOGY – Cont'd	$
C623	General assessment	41.50
C624	General re-assessment	30.05
	Subsequent visits (minor assessments):	
C622	up to five weeks per visit	12.20
C627	from sixth to thirteenth week inclusive (not to exceed $36 60 per week) per visit	12.20
C629	after thirteenth week (not to exceed $73.20 per month) per visit	12.20
C628	Concurrent care (minor assessments) per visit	12.20

Premiums for special visits; I.C.U., C.C.U.; Detention:
(see Preamble, Part B, paragraphs **23**, **24**.)

DERMATOLOGY (02)

General Listings:
(use these listings when performed at locations other than those designated in the following sections.)

A025	Consultation	37.20
A026	Repeat consultation	30.40
A023	Specific assessment	27.20
A024	**Partial** assessment	12.90

Emergency or O.P.D. — Physician in Hospital But Not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.:
(Use General Listings)

Non-emergency Hospital In-patient Services:

Note: For emergency calls and other visits to hospital in-patients for which "special visit" premiums apply, use General Listings and refer to Preamble, Part B, paragraph **23**. (If physician already in hospital, refer to paragraph **18**(d).)

C025	Consultation	37.20
C026	Repeat consultation	30.40
C023	Specific assessment	27.20
C024	Specific re-assessment	16.80
	Subsequent visits (minor assessments):	
C022	up to five weeks per visit	12.20
C027	from sixth to thirteenth week inclusive (not to exceed $36.60 per week) per visit	12.20
C029	after thirteenth week (not to exceed $73.20 per month) per visit	12.20
C028	Concurrent care (minor assessments) per visit	12.20

CONSULTATIONS AND VISITS

DERMATOLOGY – Cont'd

Long Term Institutional Care — Chronic and Convalescent Hospital, Homes for the Aged — Patients Covered by Extended Care Legislation and Nursing Homes.

Code		$
W025	Consultation	37.20
W026	Repeat consultation	30.40

Premiums for special visits; I.C.U., C.C.U.; Detention:
(see Preamble, Part B, paragraphs **23**, **24**.)

GASTROENTEROLOGY (41)

For services not listed, refer to Internal Medicine Section.

General Listings:
(Use these listings when performed at locations other than those designated in the following sections.)

A415	Consultation	76.55
A545	Limited consultation	50.10
A416	Repeat consultation	50.10
A413	General assessment	41.50
A414	General re-assessment	30.05
A418	**Partial** assessment	16.10

Emergency or O.P.D. — Physician in Hospital But Not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.:
(Use General Listings)

Non-emergency Hospital In-patient Services:

Note: For emergency calls and other visits to hospital in-patients for which "special visit" premiums apply, use General Listings and refer to Preamble, Part B, paragraph **23**. (If physician already in hospital, refer to paragraph **18**(d).)

C415	Consultation		76.55
C545	Limited consultation		50.10
C416	Repeat consultation		50.10
C413	General assessment		41.50
C414	General re-assessment		30.05
	Subsequent visits (minor assessments):		
C412	up to five weeks	per visit	12.20
C417	from sixth to thirteenth week inclusive (not to exceed $36.60 per week)	per visit	12.20
C419	after thirteenth week (not to exceed $73.20 per month)	per visit	12.20
C418	Concurrent care (minor assessments)	per visit	12.20

Premiums for Special Visits; I.C.U., C.C.U.; Detention:
(See Preamble, Part B, paragraphs **23**, **24**.)

CONSULTATIONS AND VISITS

Code	GENERAL SURGERY (03)	$
	General Listings:	
	(Use these listings when performed at locations other than those designated in the following sections.)	
A035	Consultation	39.00
A036	Repeat consultation	30.40
A033	Specific assessment	27.50
A034	**Partial** assessment	13.60
	Emergency or O.P.D. — Physician in Hospital But Not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.:	
	(Use General Listings)	
	Non-emergency Hospital In-patient Services:	
Note:	For emergency calls and office visits to hospital in-patients for which "special visit" premiums apply, use General Listings and refer to Preamble, Part B, paragraph **23**. (If physician already in hospital, refer to paragraph **18**(d).)	
C035	Consultation	39.00
C036	Repeat consultation	30.40
C033	Specific assessment	27.50
C034	Specific re-assessment	16.80
	Subsequent visits (minor assessments):	
C032	up to five weeks ... per visit	12.20
C037	from sixth to thirteenth week inclusive (not to exceed $36.60 per week) per visit	12.20
C039	after thirteenth week (not to exceed $73.20 per month) ... per visit	12.20
C038	Concurrent care (minor assessments) ... per visit	12.20
	Long Term Institutional Care — Chronic and Convalescent Hospital, Homes for the Aged — Patients Covered by Extended Care Legislation and Nursing Homes:	
W035	Consultation	39.00
W036	Repeat consultation	30.40
	Premiums for Special Visits; I.C.U., C.C.U.; Detention:	
	(see Preamble, Part B, paragraphs **23**, **24**.)	
	HAEMATOLOGY (61)	
	For Services not listed, refer to Internal Medicine Section.	
	General Listings:	
	(Use these listings when performed at locations other than those designated in the following sections.)	
A615	Consultation	76.55
A655	Limited consultation	50.10

CONSULTATIONS AND VISITS

Code	HAEMATOLOGY – Cont'd	$
A616	Repeat consultation	50.10
A613	General assessment	41.50
A614	General re-assessment	30.05
A618	**Partial** assessment	16.10

Emergency or O.P.D.: — Physician in Hospital But not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.:
(Use General Listings)

Non-emergency Hospital In-patient Services:

Note: For emergency calls and other visits to hospital in-patients for which "special visit" premiums apply, use General Listings and refer to Preamble, Part B, paragraph **23**. (If physician already in hospital, refer to paragraph **18**(d).)

C615	Consultation	76.55
C655	Limited consultation	50.10
C616	Repeat consultation	50.10
C613	General assessment	41.50
C614	General re-assessment	30.05
	Subsequent visits (minor assessments):	
C612	up to five weeks per visit	12.20
C617	from sixth to thirteenth week inclusive (not to exceed $36.60 per week) per visit	12.20
C619	after thirteenth week (not to exceed $73.20 per month) per visit	12.20
C618	Concurrent care (minor assessments)	12.20

Premiums for Special Visits; I.C.U., C.C.U.; Detention:
(See Preamble, Part B, paragraphs **23**, **24**.)

INTERNAL MEDICINE (13)

General Listings:
(Use these listings when performed at locations other than those designated in the following sections.)

A135	Consultation	76.55
A435	Limited consultation	50.10
A136	Repeat consultation	50.10
A133	General assessment	41.50
A134	General re-assessment	30.05
A138	**Partial** assessment	16.10

Emergency or O.P.D. — Physician in Hospital But Not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.:
(Use General Listings)

CONSULTATIONS AND VISITS

Code	**INTERNAL MEDICINE – Cont'd**	$
	Non-emergency Hospital In-Patient Services:	
Note:	For emergency calls and other visits to hospital in-patients for which "special visit" premiums apply, use General Listings and refer to Preamble, Part B, paragraph **23**. (If physician already in hospital, refer to paragraph **18**(d).)	
C135	Consultation	76.55
C435	Limited consultation	50.10
C136	Repeat consultation	50.10
C133	General assessment	41.50
C134	General re-assessment	30.05
	Subsequent visits (minor assessments):	
C132	up to five weeks . . . per visit	12.20
C137	from sixth to thirteenth week inclusive (not to exceed $36.60 per week) . . . per visit	12.20
C139	after thirteenth week (not to exceed $73.20 per month) . . . per visit	12.20
C138	Concurrent care (minor assessments) . . . per visit	12.20
	Long Term Institutional Care:	
Note:	For emergency calls and other visits to institutional patients for which "special visit" premiums apply, use General Listings and refer to Preamble, Part B, paragraph **23**. (If physician already in Institution, refer to paragraphs **20, 21**.)	
	1. Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, or other Institutions in which patients are covered by extended care legislation:	
W235	Consultation	76.55
W435	Limited consultation	50.10
W236	Repeat consultation	50.10
	Admission assessment (see Preamble)	
W232	Type 1	34.30
W234	Type 2	11.80
W239	Annual physical examination	30.05
W134	General re-assessment of patient in nursing home or covered by extended care legislation	16.10
Note:	May only be claimed 6 months after Annual Health Examination (as per the Nursing Homes Act).	
	Subsequent visits (minor assessments) **see Preamble, Part B, paragraphs 20, 21**).	
	— chronic care or convalescent hospital (maximum of 10 per patient, per month)	
W132	— first two visits per month (chargeable by most responsible physician) . . . per visit	12.20
W131	— subsequent visits per month . . . per visit	9.10

CONSULTATIONS AND VISITS

Code	INTERNAL MEDICINE – Cont'd		$
	— nursing home or other institution covered by extended care legislation (maximum of 5 per patient, per month)		
W133	— first visit per month (chargeable by most responsible physician)	per visit	12.20
W138	— subsequent visits per month	per visit	9.10
	2. Homes for the Aged and other Institutions in which patients are Not Covered by Extended Care Legislation:		
	(Use General Listings)		
Note:	General Listings under these circumstances also apply to patients seen in bed rather than in an office supplied by the institution.		
	Premiums for Special Visits; I.C.U., C.C.U.; Detention:		
	(See Preamble, Part B, paragraphs **23**, **24**.)		
	MICROBIOLOGY (29)		
	General Listings:		
	(Use these listings for services other than non-emergency hospital services.)		
A295	Consultation		50.10
A297	Limited consultation		34.30
A296	Repeat consultation		34.30
	Non-emergency Hospital In-patient Services:		
C295	Consultation		50.10
C297	Limited consultation		34.30
C296	Repeat consultation		34.30
C298	Concurrent care	per visit	12.20
	Outpatient Department:		
H295	Consultation		50.10
H297	Limited Consultation		34.30
H293	Repeat consultation		34.30
	Premiums for Special Visits; I.C.U., C.C.U.; Detention:		
	(See Preamble, Part B, paragraphs **23**, **24**.)		
	NEUROLOGY (18)		
	General Listings:		
	(Use these listings when performed at locations other than those designated in the following sections.)		
A185	Consultation		76.55
A385	Limited consultation		50.10

CONSULTATIONS AND VISITS

Code	**NEUROLOGY – Cont'd**	$
A186	Repeat consultation	50.10
A183	General assessment	41.50
A184	General re-assessment	30.05
A188	**Partial** assessment	16.10

Emergency or O.P.D. — Physician in Hospital But Not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.:
(Use General Listings)

Non-emergency Hospital In-patient Services:

Note: For emergency calls and other visits to hospital in-patients for which "special visit" premiums apply, use General Listings and refer to Preamble, Part B, paragraph **23**. (If physician already in hospital, refer to paragraph **18**(d).)

Code	Service		$
C185	Consultation		76.55
C385	Limited consultation		50.10
C186	Repeat consultation		50.10
C183	General assessment		41.50
C184	General re-assessment		30.05
	Subsequent visits (minor assessments):		
C182	up to five weeks	per visit	12.20
C187	from sixth to thirteenth week inclusive (not to exceed $36.60 per week)	per visit	12.20
C189	after thirteenth week (not to exceed $73.20 per month)	per visit	12.20
C188	Concurrent care (minor assessments)	per visit	12.20

Long Term Institutional Care — Chronic and Convalescent Hospital, Homes for the Aged — Patients Covered by Extended Care Legislation and Nursing Homes:

Code	Service	$
W185	Consultation	76.55
W385	Limited consultation	50.10
W186	Repeat consultation	50.10

Premiums for Special Visits; I.C.U., C.C.U.; Detention:
(See Preamble, Part B, paragraphs **23**, **24**.)

NEUROSURGERY (04)

General Listings:
(Use these listings when performed at locations other than those designated in the following sections.)

Code	Service	$
A045	Consultation	57.20
A046	Repeat consultation	32.55
A043	Specific assessment	32.55
A044	**Partial** assessment	16.10

Code	NEUROSURGERY - Cont'd	$
	Emergency or O.P.D. — Physician in Hospital But Not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.:	
	(Use General Listings)	
	Non-emergency Hospital In-patient Services:	
Note:	For emergency calls and other visits to hospital in-patients for which "special visit" premiums apply, use General Listings and refer to Preamble, Part B, paragraph **23**. (If physician already in hospital, refer to paragraph **18**(d).)	
C045	Consultation	57.20
C046	Repeat consultation	32.55
C043	Specific assessment	32.55
C044	Specific re-assessment	16.80
	Subsequent visits (minor assessments):	
C042	up to five weeks . . . per visit	12.20
C047	from sixth to thirteenth week inclusive (not to exceed $36.60 per week) . . . per visit	12.20
C049	after thirteenth week (not to exceed $73.20 per month) . . . per visit	12.20
C048	Concurrent care (minor assessments) . . . per visit	12.20
	Long Term Institutional Care — Chronic and Convalescent Hospital, Homes for the Aged — Patients Covered by Extended Care Legislation and Nursing Homes:	
W045	Consultation	57.20
W046	Repeat consultation	32.55

Premiums for Special Visits; I.C.U., C.C.U.; Detention:
(see Preamble, Part B, paragraphs **23**, **24**.)

NUCLEAR MEDICINE (63)

G635	Consultation	42.90
G634	Repeat consultation	30.80
G935	Diagnostic consultation — see definition in Preamble	19.10
G632	**Partial** assessment	16.10

Premiums for Special Visits; I.C.U., C.C.U.; Detention:
(See Preamble, Part B, paragraphs **23**, **24**.)

CONSULTATIONS AND VISITS

Code	OBSTETRICS AND GYNAECOLOGY (20)	$
	General Listings: (Use these listings when performed at locations other than those designated in the following sections.)	
A205	Consultation*	38.60
A206	Repeat consultation*	30.40
A203	Specific assessment*	27.50
A204	**Partial** assessment*	13.60
	Emergency or O.P.D. — Physician in Hospital But Not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.: (Use General Listings)	
	Non-emergency Hospital In-patient Services:	
Note:	For emergency calls and other visits to hospital in-patients for which "special visit" premiums apply, use General Listings and refer to Preamble, Part B, paragraph **23**. (If physician already in hospital, refer to paragraph **18**(d).)	
C205	Consultation*	38.60
C206	Repeat consultation*	30.40
C203	Specific assessment*	27.50
C204	Specific re-assessment*	16.80
	Subsequent visits (minor assessments):	
C202	up to five weeks . . . per visit	12.20
C207	from sixth to thirteenth week inclusive (not to exceed $36.60 per week) . . . per visit	12.20
C209	after thirteenth week (not to exceed $73.20 per month) . . . per visit	12.20
C208	Concurrent care (minor assessments) . . . per visit	12.20
	Long Term Institutional Care — Chronic and Convalescent Hospitals, Homes for the Aged — Patients Covered by Extended Care Legislation and Nursing Homes:	
W305	Consultation*	38.60
W306	Repeat consultation*	30.40
	Premiums for Special Visits; I.C.U., C.C.U.; Detention: (See Preamble, Part B, paragraphs **23**, **24**.)	

*May include chemical cautery, biopsy of cervix, Papanicolaou smear, examination of trichomonas suspension.

CONSULTATIONS AND VISITS

Code	OPHTHALMOLOGY (23)	$
	General Listings:	
	(Use these listings when performed at locations other than those designated in the following sections.)	
A235	Consultation	38.30
A236	Repeat consultation	30.40
A233	Specific assessment	27.50
A234	**Partial** assessment	13.60
	Emergency or O.P.D. — Physician in Hospital But Not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.:	
	(Use General Listings)	
	Non-emergency Hospital In-patient Services:	
Note:	For emergency calls and other visits to hospital in-patients for which "special visit" premiums apply, use General Listings and refer to Preamble, Part B, paragraph **23**. (If physician already in hospital, refer to paragraph **18**(d).)	
C235	Consultation	38.30
C236	Repeat consultation	30.40
C233	Specific assessment	27.50
C234	Specific re-assessment	16.80
	Subsequent visits (minor assessments):	
C232	up to five weeks per visit	12.20
C237	from sixth to thirteenth week inclusive (not to exceed $36.60 per week) per visit	12.20
C239	after thirteenth week (not to exceed $73.20 per month) per visit	12.20
C238	Concurrent care (minor assessments) per visit	12.20
	Long Term Institutional Care — Chronic and Convalescent Hospital, Homes for the Aged — Patients Covered by Extended Care Legislation and Nursing Homes:	
W535	Consultation	38.30
W536	Repeat consultation	30.40
	Premiums for Special Visits; I.C.U., C.C.U.; Detention:	
	(see Preamble, Part B, paragraphs **23**, **24**.)	
	ORTHOPAEDIC SURGERY (06)	
	General Listings:	
	(Use these listings when performed at locations other than those designated in the following sections.)	
A065	Consultation	35.80
A066	Repeat consultation	28.60
A063	Specific assessment	25.00

CONSULTATIONS AND VISITS

Code	**ORTHOPAEDIC SURGERY - Cont'd**	$
A064	**Partial** assessment	13.20
	Emergency or O.P.D. — Physician in Hospital But Not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.:	
	(Use General Listings)	
	Non-emergency Hospital In-patients Services:	
Note:	For emergency calls and other visits to hospital in-patients for which "special visit" premiums apply, use General Listings and refer to Preamble, Part B, paragraph **23**. (If physician already in hospital, refer to paragraph **18**(d).)	
C065	Consultation	35.80
C066	Repeat consultation	28.60
C063	Specific assessment	25.00
C064	Specific re-assessment	15.70
	Subsequent visits (minor assessments):	
C062	up to five weeks . . . per visit	10.70
C067	from sixth to thirteenth week inclusive (not to exceed $32.10 per week) . . . per visit	10.70
C069	after thirteenth week (not to exceed $64.20 per month) . . . per visit	10.70
C068	Concurrent care (minor assessments) . . . per visit	10.70
	Long Term Institutional Care — Chronic and Convalescent Hospital, Homes for the Aged — Patients Covered by Extended Care Legislation and Nursing Homes:	
W065	Consultation	35.80
W066	Repeat consultation	28.60
	Subsequent visits (minor assessments **see Preamble Part B, Paragraphs 20, 21**).	
	— chronic care or convalescent hospital (maximum of 10 per patient, per month)	
W062	— first two visits per month (chargeable by most responsible physician) . . . per visit	10.70
W061	— subsequent visits per month . . . per visit	9.10
	— nursing home or other institution covered by extended care legislation (maximum of 5 per patient, per month)	
W063	— first visit per month (chargeable by most responsible physician) . . . per visit	10.70
W068	— subsequent visits per month . . . per visit	9.10

Premiums for Special Visits; I.C.U., C.C.U.; Detention:
(See Preamble, Part B, paragraphs **23**, **24**.)

Code	**OTOLARYNGOLOGY (24)**	$
	General Listings: (Use these listings when performed at locations other than those designated in the following sections.)	
A245	Consultation	38.30
A246	Repeat consultation	30.40
A243	Specific assessment	27.50
A244	**Partial** assessment	13.60
	Emergency or O.P.D. — Physician in Hospital But Not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.: (Use General Listings)	
	Non-emergency Hospital In-patient Services:	
Note:	For emergency calls and other visits to hospital in-patients for which "special visit" premiums apply, use General Listings and refer to Preamble, Part B, paragraph **23**. (If physician already in hospital, refer to paragraph **18**(d).)	
C245	Consultation	38.30
C246	Repeat consultation	30.40
C243	Specific assessment	27.50
C244	Specific re-assessment	16.80
	Subsequent visits (minor assessments):	
C242	up to five weeks . . . per visit	12.20
C247	from sixth to thirteenth week inclusive (not to exceed $36.60 per week) . . . per visit	12.20
C249	after thirteenth week (not to exceed $73.20 per month) . . . per visit	12.20
C248	Concurrent care (minor assessments) . . . per visit	12.20
	Long Term Institutional Care — Chronic and Convalescent Hospital, Homes for the Aged — Patients Covered by Extended Care Legislation and Nursing Homes:	
W345	Consultation	38.30
W346	Repeat consultation	30.40
	Premiums for Special Visits; I.C.U., C.C.U.; Detention: (See Preamble, Part B, paragraphs **23, 24**.)	
	PAEDIATRICS (26)	
	General Listings: (Use these listings when performed at locations other than those designated in the following sections.)	
A265	Consultation	76.55
A665	Prenatal consultation (see Preamble, Part B, paragraph 1(**K**))	46.50
A565	Limited consultation	50.10
A266	Repeat consultation	50.10

CONSULTATIONS AND VISITS

Code	**PAEDIATRICS – Cont'd**	$
A263	General assessment	35.80
A264	General re-assessment	23.25
A007	**Intermediate** assessment/**Well baby care**	16.10
A261	Minor assessment	11.80
K267	Annual health examination — child (after 2nd birthday)	20.70
K269	— adolescent	30.05
	Diagnostic interview and/or counselling with child and/or parent — **see Practice in General Listing (K008)**	
	Emergency or O.P.D. — Physician in Hospital But Not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.:	
	(Use General Listings)	
	Non-emergency Hospital In-patient Services:	
Note:	For emergency calls and other visits to hospital in-patients for which "special visit" premiums apply, use General Listings and refer to Preamble, Part B, paragraph **23**. (If physician already in hospital, refer to paragraph **18**(d).)	
C265	Consultation	76.55
C665	Prenatal consultation (See Preamble, part B, paragraph **1(K)**)	46.50
C565	Limited consultation	50.10
C266	Repeat consultation	50.10
C263	General assessment	35.80
C264	General re-assessment	23.25
	Subsequent visits (minor assessments):	
C262	up to six weeks per visit	12.20
C267	from seventh to thirteenth week inclusive (not to exceed $36.60 per week) per visit	12.20
C269	after thirteenth week (not to exceed $73.20 per month) per visit	12.20
C268	Concurrent care (minor assessments) per visit	12.20
H267	Attendance at maternal delivery (one or more babies)	42.90
Note:	Consultation should not be claimed with attendance of maternal delivery other fees may apply. (See Obstetrical Preamble, paragraph 11.)	
H261	Newborn care in hospital and/or home	39.35
	Low birthweight baby care (uncomplicated)	
H262	— initial visit (per baby)	34.30
H263	— thereafter per visit	11.80
U.V.C.	— Intensive care unit (without assisted ventilation) (See Preamble, Part B, paragraph **23**(b)) visit fees	
N.C.	Pre-adoption examination and evaluation	N.A.B.

CONSULTATIONS AND VISITS

Code	**PAEDIATRICS – Cont'd**	$
	Chronic and Convalescent Hospital:	
W265	Consultation	76.55
W565	Limited consultation	50.10
W266	Repeat consultation	50.10
	Admission assessment (see Preamble)	
W562	Type 1	34.30
W564	Type 2	11.80
	Subsequent visits (minor assessments **See Preamble Part B, paragraphs 20, 21**).	
	— chronic care or convalescent hospital (maximum of 10 per patient, per month)	
W262	— first two visits per month (chargeable by most responsible physician) . per visit	12.20
W261	— subsequent visits per month per visit	8.40
W269	Annual physical examination	20.70
Note:	In surgical cases requiring medical direction, standard in-hospital medical benefits may be claimed in addition to the surgical benefit. This includes all operations on babies under one year of age, and all other children who require medical supervision.	

Premiums for Special Visits; I.C.U., C.C.U.; Detention:
(See Preamble, Part B, paragraphs **23, 24**.)

PATHOLOGY (28)

General Listings:
(Use these listings for services other than non-emergency in-patient services.)

Code	Service	$
A285	Consultation	50.10
A286	Repeat or limited consultation	34.30
A585	Diagnostic consultation — see definition in Preamble	19.10

Non-emergency Hospital In-patient Services:

Code	Service	$
C285	Consultation	50.10
C286	Repeat or limited consultation	34.30
C585	Diagnostic consultation	19.10
C288	Concurrent care per visit	12.20

Premiums for Special Visits; I.C.U., C.C.U.; Detention:
(See Preamble, Part B, paragraphs **23, 24**.)

CONSULTATIONS AND VISITS

Code	PHYSICAL MEDICINE AND REHABILITATION (31)	$
	General Listings:	
	(Use these listings when performed at locations other than those designated in the following sections.)	
A315	Consultation	76.55
A515	Limited consultation	50.10
A316	Repeat consultation	50.10
A313	General assessment	41.50
A310	General re-assessment	30.05
A314	**Partial** assessment	16.10
	Emergency or O.P.D. — Physician in Hospital But Not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.:	
	(Use General Listings)	
	Non-emergency Hospital In-patient Services:	
Note:	For emergency calls and other visits to hospital in-patients for which "special visit" premiums apply, use General Listings and refer to Preamble, Part B, paragraph **23**. (If physician already in hospital, refer to paragraph **18**(d).)	
C315	Consultation	76.55
C515	Limited consultation	50.10
C316	Repeat consultation	50.10
C313	General assessment	41.50
C314	General re-assessment	30.05
	Subsequent visits (minor assessments):	
C312	up to five weeks ... per visit	12.20
C317	from sixth to thirteenth week inclusive (not to exceed $36.60 per week) ... per visit	12.20
C319	after thirteenth week (not to exceed $73.20 per month) ... per visit	12.20
C318	Concurrent care (minor assessments) ... per visit	12.20
	Long Term Institutional Care:	
Note:	For emergency calls and other visits to institutional patients for which "special visit" premiums apply, use General Listings and refer to Preamble, Part B, paragraph **23**. (If physician already in Institution, refer to paragraph **20**.)	
	1. Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes or other Institutions in which patients are covered by extended care legislation:	
W515	Consultation	76.55
W310	Limited consultation	50.10
W516	Repeat consultation	50.10
	Admission assessment (see Preamble)	
W512	Type 1	34.30
W514	Type 2	11.80
W419	Annual physical examination	30.05

CONSULTATIONS AND VISITS

Code	**PHYSICAL MEDICINE AND REHABILITATION – Cont'd**	$
W314	General re-assessment of patient in nursing home or covered by extended care legislation	16.10
	May only be claimed 6 months after Annual Health Examination (as per the Nursing Homes Act).	
	Subsequent visits (minor assessments **See Preamble Part B, paragraphs 20, 21**)	
	— chronic care or convalescent hospital (maximum of 10 per patient, per month)	
W312	— first two visits per month (chargeable by most responsible physician) . per visit	12.20
W311	— subsequent visits per month per visit	9.10
	— nursing home or other institution covered by extended care legislation (maximum of 5 per patient, per month)	
W313	— first visit per month (chargeable by most responsible physician) per visit	12.20
W318	— subsequent visits per month per visit	9.10
	2. Homes for the Aged and other Institutions in which patients are Not Covered by Extended Care Legislation.	
	(Use General Listings)	
Note:	General Listings under these circumstances also apply to patients seen in bed rather than in an office supplied by the institution.	
	Premiums for Special Visits; I.C.U., C.C.U.; Detention: (See Preamble, Part B, paragraphs **23, 24**.)	
	Team Management in a Rehabilitation Unit: (Active in-patient rehabilitation management from the initiation of rehabilitation care as it applies to codes H312, H317 and H319 means, when this service is rendered by one physiatrist (even if part of the service is rendered in an active treatment hospital and part is rendered in a rehabilitation unit), the weekly and monthly limitations under these codes apply to the total rehabilitation care rendered. In other words, it is not possible to claim the maximum benefits allowed under codes C312, C317 and C319 and submit claims de novo under codes H312, H317 and H319 under the above circumstances.)	
H312	up to twelve weeks per visit	12.20
H317	from thirteenth to twenty-sixth week (not to exceed $36.60 per week) per visit	12.20
H319	twenty-sixth week onwards (not to exceed $73.20 per month) . . . per visit	12.20

Code	**PHYSICAL MEDICINE AND REHABILITATION – Cont'd**	$
	Rehabilitation Procedures:	
H313	Interviewing and counselling of patients and/or relatives per half hour or major part thereof (includes report)	30.80
N.C.	Rehabilitation case conference — with medical and/or paramedical personnel on behalf of a patient	N.A.B.
K313	Physiatric Management: applies to physiatrists regulating the day to day management of patients which may include (as required) prescription development, advice and supervision. It may be claimed on the days when rehabilitation services are provided to patients who have been seen previously by the physiatrist for consultation or assessment. The benefit is not meant as an administrative allowance for supervising a department of rehabilitation nor is it to be claimed on the same day as claims are made for any other services which are provided by the physiatrist to the same patient(s)	2.20
	PLASTIC SURGERY (08)	
	General Listings:	
	(Use these listings when performed at locations other than those designated in the following sections.)	
A085	Consultation	37.20
A086	Repeat consultation	30.40
A083	Specific assessment	27.20
A084	**Partial** assessment	13.60
	Emergency or O.P.D. — Physician in Hospital But Not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.:	
	(Use General Listings)	
	Non-emergency Hospital In-patient Services:	
Note:	For emergency calls and other visits to hospital in-patients for which "special visit" premiums apply, use General Listings and refer to Preamble, Part B, paragraph **23**. (If physician already in hospital, refer to paragraph **18**(d).)	
C085	Consultation	37.20
C086	Repeat consultation	30.40
C083	Specific assessment	27.20
C084	Specific re-assessment	16.80
	Subsequent visits (minor assessments):	
C082	up to five weeks . . . per visit	12.20
C087	from sixth to thirteenth week inclusive (not to exceed $36.60 per week) . . . per visit	12.20
C089	after thirteenth week (not to exceed $73.20 per month) . . . per visit	12.20
C088	Concurrent care (minor assessments) . . . per visit	12.20

CONSULTATIONS AND VISITS

Code	PLASTIC SURGERY - Cont'd	$
	Long Term Institutional Care — Chronic and Convalescent Hospital, Homes for the Aged — Patients Covered by Extended Care Legislation and Nursing Homes:	
W085	Consultation	37.20
W086	Repeat consultation	30.40
	Premiums for Special Visits; I.C.U., C.C.U.; Detention: (See Preamble, Part B, paragraphs **23**, **24**.)	
	PSYCHIATRY (19)	
	General Listings: (Use these listings when performed at locations other than those designated in the following sections.)	
A195	Consultation	76.55
A395	Limited consultation	50.10
A196	Repeat consultation	50.10
A193	Specific assessment	41.50
A194	**Partial** assessment	16.10
	Emergency or O.P.D. — Physician in Hospital But Not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.: (Use General Listings)	
	Non-emergency Hospital Services: (in-patient, day care, residential care).	
Note:	For emergency calls and other visits to hospital in-patients for which "special visit" premiums apply, use General Listings and refer to Preamble, Part B, paragraph **23**. (If physician already in hospital, refer to paragraph **18**(d).)	
C195	Consultation	76.55
C395	Limited consultation	50.10
C196	Repeat consultation	50.10
C193	Specific assessment	41.50
C194	Specific re-assessment	30.05
	Subsequent visits (minor assessment):	
C192	up to five weeks .per visit	12.20
C197	from sixth to thirteenth week inclusive (not to exceed $36.60 per week) .per visit	12.20
C199	after thirteenth week (not to exceed $73.20 per month) .per visit	12.20
C198	Concurrent care (minor assessment) .per visit	12.20

CONSULTATIONS AND VISITS

Code	**PSYCHIATRY - Cont'd**	**$**
	Long Term Institutional Care — Chronic and Convalescent Hospital, Homes for the Aged — Patients Covered by Extended Care Legislation and Nursing Homes:	
W195	Consultation	76.55
W395	Limited consultation	50.10
W196	Repeat consultation	50.10
	Other Services:	
	Certification of Mental Illness	
K623	Application for psychiatric assessment, (as mandated by the Mental Health Act) — including necessary history, examination and completion of form	50.10
K624	Certification and re-certification of involuntary admission (as required by the Mental Health Act at not more than 120 hours and 2 weeks) — to include history, examination and completion of form, per ½ hour or major part thereof	36.20
K629	**All other re-certification(s) of involuntary admission**	19.30
N.C.	**Certification of incompetence including assessment to determine incompetence**	**N.A.B.**
Note:	Consultation or assessment normally may not be claimed in addition to certification or re-certification (same visit).	
N.C.	Specific assessment with report to referring agency	N.A.B.
	Consultation on behalf of disturbed child (including report):	
A197	consultative interview with parents	71.55
A198	consultative interview with child	71.55
	(Assessment conference with parents should be claimed on the basis of family therapy).	
N.C.	Therapeutic supervision with any para-medical organization (health education, correction and other community resources)	N.A.B.
N.C.	**Appearance before Advisory Review Board or Review Board — per ½ hr. or major part thereof**	**N.A.B.**
K620	**Consultation for involuntary psychiatric treatment (as mandated by Section 35(4b) of the Mental Health Act) — per ½ hr. or major part thereof**	36.20
Note:	Interviews with relatives, C.A.S. or Legal guardian on behalf of a patient, see K002, K003 on page 36.	
	Psychotherapy: (See Preamble, Part B, paragraph **12**)	
K197	Individual (including Aversive Conditioning, Narcoanalysis, Psychoanalysis) per ½ hour or major part thereof	36.20
	Group psychotherapy **out patients**	
K198	per member, per ½ hour or major part thereof (up to six hours per day) **4-8 people**	6.30
K199	**per member, per ½ hour or major part thereof (up to 6 hours per day) 9-12 people**	5.00
N.C.	per member, per hour (more than 6 hours)	N.A.B.

CONSULTATIONS AND VISITS

Code	PSYCHIATRY – Cont'd	$
	Group psychotherapy IN Patients.	
K191	**per member, per ½ hour or major part thereof (up to 6 hours per day) 4-8 people**	6.30
K196	**per member, per ½ hour or major part thereof (up to 6 hours per day) 9-12 people**	5.00
N.C.	**per member, per ½ hour (more than 6 hours)**	**N.A.B.**
	Family therapy (two or more family members)	
K195	per ½ hour or major part thereof	41.10
Note:	Should be claimed on the patient's claim card with diagnosis.	
	Hypnotherapy:	
K192	Individual — per ½ hour or major part thereof	36.20
Note:	May not be claimed with diagnosis of acne, psoriasis, smoking, obesity or in conjunction with delivery.	
K194	Group — for induction and training for hypnosis (up to eight people) per ½ hour or major part thereof — per member — (not applicable to prenatal patients)	6.30
Note:	(1) For electroconvulsive therapy benefits, see Diagnostic and Therapeutic Procedures. (2) Psychotherapy or hypnotherapy or counselling or E.C.T. is not to be claimed in conjunction with other consultations or assessments rendered by the same physician on the same day, unless there are clearly defined unrelated diagnoses for the two services. (3) The College of Phyicians and Surgeons has stated that the minimum time period for psychotherapy (to be claimed as such) is 20 minutes (see Preamble, Part B, paragraph 12).	

Premiums for Special Visits; I.C.U., C.C.U.; Detention:
(See Preamble, Part B, paragraphs 23, 24.)

RADIOLOGY — DIAGNOSTIC (33)

General Listing:

A335	Consultation (See Preamble, Part B, paragraph 1(e)	19.50

Non-Emergency Hospital Service:

C335	Consultation (See Preamble, Part B, paragraph 1(e)	19.50

Premiums for Special Visits; I.C.U., C.C.U.; Detention:
(See Preamble, Part B, paragraphs 23, 24.)

RADIATION ONCOLOGY — (THERAPEUTIC RADIOLOGY) (34)

General Listings:
(Use these listings when performed at locations other than those designated in the following sections.)

A345	Consultation	45.40
A346	Repeat consultation	30.40
A343	Specific assessment	27.50
A344	**Partial** assessment	13.60

Code	RADIATION ONCOLOGY — (THERAPEUTIC RADIOLOGY) – Cont'd		$
	Non-emergency Hospital In-patient Services:		
Note:	For emergency calls and other visits to hospital in-patients for which "special visit" premiums apply, use General Listings and refer to Preamble, Part B, paragraph **23**. (If physician already in hospital, refer to paragraph **18**(d).)		
C345	Consultation		45.40
C346	Repeat consultation		30.40
C343	Specific assessment		27.50
C344	Specific re-assessment		16.80
	Subsequent visits (minor assessments):		
C342	up to five weeks	per visit	12.20
C347	from sixth to thirteenth week inclusive (not to exceed $36.60 per week)	per visit	12.20
C349	after thirteenth week (not to exceed $73.20 per month)	per visit	12.20
C348	Concurrent care (minor assessments)	per visit	12.20

Premiums for Special Visits; I.C.U., C.C.U.; Detention:
(see Preamble, Part B, paragraphs **23**, **24**.)

RESPIRATORY DISEASE (47)
For services not listed, refer to Internal Medicine Section.

General Listings:
(Use these listings when performed at locations other than those designated in the following sections.)

Code		$
A475	Consultation	76.55
A575	Limited consultation	50.10
A476	Repeat consultation	50.10
A473	General assessment	41.50
A474	General re-assessment	30.05
A478	**Partial** assessment	16.10

Emergency or O.P.D. — Physician in Hospital But Not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.:
(Use General Listings)

Non-emergency Hospital In-patient Services:

Code		$
Note:	For emergency calls and other visits to hospital in-patients for which "special visit" premiums apply, use General Listings and refer to Preamble, Part B, paragraph **23**. (If physician already in hospital, refer to paragraph **18**(d).)	
C475	Consultation	76.55
C575	Limited consultation	50.10
C476	Repeat consultation	50.10
C473	General assessment	41.50
C474	General re-assessment	30.05

Code	RESPIRATORY DISEASE – Cont'd	$
	Subsequent visits (minor assessments):	
C472	up to five weeks .... per visit	12.20
C477	from sixth to thirteenth week inclusive (not to exceed $36.60 per week) .... per visit	12.20
C479	after thirteenth week (not to exceed $73.20 per month) .... per visit	12.20
C478	Concurrent care (minor assessments) .... per visit	12.20

Premiums for Special Visits; I.C.U., C.C.U.; Detention:
(See Preamble, Part B, paragraphs 23, 24.)

RHEUMATOLOGY (48)

For services not listed, refer to Internal Medicine Section.

General Listings:
(Use these listings when performed at locations other than those designated in the following sections.)

Code		$
A485	Consultation	76.55
A595	Limited consultation	50.10
A486	Repeat consultation	50.10
A483	General assessment	41.50
A484	General re-assessment	30.05
A488	**Partial** assessment	16.10

Emergency or O.P.D. — Physician in Hospital But Not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.:
(Use General Listings)

Non-emergency Hospital In-patient Services:

Note: For emergency calls and other visits to hospital in-patients for which "special visit" premiums apply, use General Listings and refer to Preamble, Part B, paragraph 23. (If physician already in hospital, refer to paragraph 18(d).)

Code		$
C485	Consultation	76.55
C595	Limited consultation	50.10
C486	Repeat consultation	50.10
C483	General assessment	41.50
C484	General re-assessment	30.05
	Subsequent visits (minor assessments):	
C482	up to five weeks .... per visit	12.20
C487	from sixth to thirteenth week inclusive (not to exceed $36.60 per week) .... per visit	12.20
C489	after thirteenth week (not to exceed $73.20 per month) .... per visit	12.20
C488	Concurrent care (minor assessments) .... per visit	12.20

Premiums for Special Visits; I.C.U., C.C.U.; Detention:
(See Preamble, Part B, paragraphs 23, 24.)

CONSULTATIONS AND VISITS

Code	UROLOGY (35)	$
	General Listings:	
	(Use these listings when performed at locations other than those designated in the following sections.)	
A355	Consultation*	37.90
A356	Repeat consultation*	30.40
A353	Specific assessment*	27.20
A354	**Partial** assessment*	13.60
	Emergency or O.P.D. — Physician in Hospital But not on Duty in the Emergency Department When Seeing Patient(s) in the Emergency or O.P.D.:	
	(Use General Listings)	
	Non-emergency Hospital In-patient Services:	
Note:	For emergency calls and other visits to hospital in-patients for which "special visit" premiums apply, use General Listings and refer to Preamble, Part B, paragraph **23**. (If physician already in hospital, refer to paragraph **18**(d).)	
C355	Consultation*	37.90
C356	Repeat consultation*	30.40
C353	Specific assessment*	27.20
C354	Specific re-assessment*	16.80
	Subsequent visits (minor assessments):	
C352	up to five weeks ... per visit	12.20
C357	from sixth to thirteenth week inclusive (not to exceed $36.60 per week) ... per visit	12.20
C359	after thirteenth week (not to exceed $73.20 per month) ... per visit	12.20
C358	Concurrent care (minor assessments) ... per visit	12.20
	Long Term Institutional Care — Chronic and Convalescent Hospital, Homes for the Aged — Patients Covered by Extended Care Legislation and Nursing Homes:	
W355	Consultation*	37.90
W356	Repeat consultation*	30.40
	Premiums for Special Visits; I.C.U., C.C.U.; Detention:	
	(See Preamble, Part B, paragraphs **23**, **24**.)	

*May include physical examination pertaining to the genito-urinary tract and when necessary such procedures as urethral calibration and prostatic fluid examination, but not to include endoscopic examination.

NUCLEAR MEDICINE — IN VIVO

Column T — is the technical benefit for the production of records, radiopharmaceutical agents, apparatus, premises, technical services, administration and secretarial services.

Column P_1 — is the professional benefit for supervision of the procedure, appropriate patient interview and/or examination, correlation of related data, interpretation of results, and provision of a written report. **The physician need not be continuously present in the nuclear medicine department or private facility while the procedures are being carried out but must be physically present frequently enough to carry out the appropriate patient interview and/or examination and approve, modify or intervene in the procedures as required.**

Column P_2 — is the professional benefit for interpretation of results and provision of a written report. If the physician **does not meet the criteria for P_1** or if any visit is claimed in conjunction with that Nuclear Medicine procedure, the lesser professional benefit (P_2) should be claimed.

Notes: (1) The total benefit is arrived at by adding T plus P_1 (first code listed, e.g. Z006) or by adding T plus P_2 (second code listed, e.g. Z925).

When coding the total benefit use suffix A
When coding the technical portion only use suffix B
When coding the professional portion only use suffix C.

(2) If quantification or data manipulation is carried out in addition to visual inspection of imaging studies, add 30% to the appropriate professional benefit. Such activity must add significant diagnostic information not available by inspection alone and does not include simple image enhancement techniques such as smoothing, background subtraction, etc. Recording of images on videotape for replay and production of images on the video display of a computer do not in themselves justify the additional benefit.

For services for which this additional 30% is appropriate the correct code prefix is Y instead of Z. For example for Arteriography plus data manipulation, the appropriate codes are Y006/Y925 instead of Z006/Z925.

The benefits for cardiac wall motion studies and calculation of ventricular ejection fraction (Z010 and Z012) already include an allowance for data manipulation. Additional benefits may be claimed **only when additional cardiac quantifications are performed i.e. stroke volume ratio and volume response curves and/or phase analysis.**

(3) If examination of Brain, Lung, Liver or Spleen is limited to one view, the benefit (T and P_1 or P_2) is to be reduced by 50% (use codes Z036/Z957, Z041/Z935, Z080/Z990 respectively).

(4) Repeat studies on the same day may be claimed only after exercise or drug intervention.

(5) The phrase "nuclear medicine specialist" should be interpreted as "nuclear medicine physician", since not all physicians practising nuclear medicine are certified as specialists in this discipline by the Royal College of Physicians and Surgeons.

(6) See also Preamble, part B, paragraph 1(h), 1(i) and 1(j).

NUCLEAR MEDICINE — IN VIVO

Code	**Cardiovascular System**	T $	P_1 $	P_2 $
Z006/Z925	Arteriography — aorta and its branches, — uni or bilateral	68.90	21.50	10.50
Z008/Z927	Venography — uni or bilateral	68.90	24.10	11.80
Z013/Z928	— mediastinum and superior vena cava	41.35	24.10	11.80
Z007/Z926	Blood flow study in conjunction with static organ scan	27.50	12.10	5.90
Z004/Z922	Cardiac output	27.50	14.40	7.10
Z024/Z924	Cardioangiography	68.90	21.50	11.80
Z005/Z991	Myocardial perfusion scan — with Thallium^{201}	143.20	25.10	12.80
Z025/Z994	Delayed Thallium^{201} myocardial perfusion scan	27.50	25.10	12.80
Z017/Z964	Myocardial perfusion scan — using other radionuclides	76.55	25.10	12.80
Z016/Z960	Myocardial scan — acute infarction, injury	68.90	21.50	10.50
	Myocardial wall motion studies			
Z010/Z923	— two or more projections	91.50	42.85	21.00
Z009/Z992	— repeat same day (maximum of 3 repeats)	27.50	21.50	—
Z012/Z988	Myocardial wall motion studies with ejection fraction	91.50	57.20	28.20
Z011/Z993	— repeat same day (maximum of 3 repeats)	27.50	28.70	—
Z018/Z965	Pericardial effusion scan	38.60	14.40	7.10
Z023/Z983	Detection and localization of venous thrombosis using radio iodonated fibrinogen up to ten days	91.50	22.25	10.90
	Endocrine System			
Z022/Z982	Adrenal scan	143.20	35.90	7.10
Z027/Z930	Thyroid uptake per determination	19.90	11.50	2.90
Z078/Z974	Thyroid scan	48.20	21.20	7.10
Z019/Z975	Thyroid scan with uptake using same radio pharmaceutical	58.95	32.60	7.10
Z074/Z971	Parathyroid scan	68.90	24.10	7.10
	Gastrointestinal System			
Z040/Z934	Radio-labelled fat absorption study	24.50	7.20	7.10
Z043/Z936	Schilling test	39.10	7.20	7.10
Z044/Z937	Schilling test — repeat with intrinsic factor, or other	19.50	3.60	3.50
Z015/Z938	Schilling test with dual isotopes and intrinsic factor.	39.10	9.30	9.15
Z057/Z939	C^{14} labelled metabolite breath test	45.90	7.20	7.10
Z045/Z940	Protein loss or gastrointestinal bleeding	68.90	14.40	14.10
Z046/Z941	Ca^{47} absorption study	68.90	14.40	14.10
Z031/Z996	**Oesophageal motility study in the supine or upright position, liquid or solid bolus**	68.90	24.10	10.50
Z032/Z997	**— repeat (maximum of 3 repeats)**	34.45	12.05	5.25
Z042/Z942	Gastrointestinal transit or reflux study	68.90	24.10	10.50
Z088/Z977	Abdominal scan (ectopic gastric mucosa, G.I. bleed and shunt patency)	68.90	21.50	11.30

NUCLEAR MEDICINE — IN VIVO

Code	Gastrointestinal System — cont'd	T $	P_1 $	P_2 $
Z047/Z943	Pancreatic study (Selenium)	143.20	14.95	7.30
Z073/Z970	Pancreatic scan	143.20	24.10	11.80
Z058/Z951	Dynamic biliary excretion	68.90	24.10	11.80
Z070/Z966	Liver and/or spleen scan	68.90	21.50	10.50
Z089/Z978	Salivary gland study	68.90	24.10	11.80
	Genitourinary System			
Z063/Z953	Dynamic renal imaging study	68.90	24.10	11.80
Z060/Z952	Renogram (time-activity curves only)	38.30	14.40	7.10
Z076/Z973	Renal scan (static image only)	48.20	14.40	7.10
Z061/Z954	Renal plasma flow	38.30	14.95	7.30
Z062/Z955	Glomerular filtration rate	45.90	14.95	7.30
Z026/Z956	Cystogram for vesicoureteral reflux	68.90	24.10	11.80
Z075/Z972	Placenta	45.90	14.40	7.10
Z021/Z981	Testicles and scrotum	68.90	24.10	7.10
	Hematopoietic System			
Z001/Z919	Plasma volume	19.90	5.00	4.90
Z002/Z920	Plasma volume with repeat studies	27.50	5.00	4.90
Z003/Z921	Red cell volume	29.10	4.30	4.20
Z050/Z945	Plasma iron clearance	49.00	7.20	7.10
Z051/Z946	Plasma iron turnover	49.00	7.20	7.10
Z052/Z947	Fe^{59} red cell utilization	49.00	14.40	7.10
Z053/Z948	Combination of Z050, Z051, Z052 at one time	107.20	14.40	14.10
Z054/Z949	Red or white cell or platelet survival	68.90	22.40	10.90
Z055/Z950	Red or white cell or platelet survival and serial surface counts	107.20	29.80	14.70
	Musculoskeletal System			
Z065/Z961	Whole body survey — bones, joints, soft tissue, marrow	91.90	32.90	16.20
Z049/Z962	Specific site — one or more	61.20	24.10	11.80
Z038/Z958	Whole body ^{67}gallium or radioactive indium scanning	114.80	35.80	17.60
Z039/Z959	^{67}Gallium scanning or radioactive indium specific site	84.20	25.00	12.80
Z056/Z984	Bone mineral density by Gamma ray scattering	24.50	7.20	7.10
Z092/Z985	Total body calcium	—	15.10	7.40
Z035/Z995	**Bone mineral content of lumbar spine or femoral neck by dual-photon absorbitometry**	117.95	31.10	15.60
Note:	Z065/Z961 and Z049/Z962 are not to be billed together. Z007/Z926 may be billed in addition to Z065/Z961 or Z049/Z962 for blood pool study.			
	Nervous System			
Z064/Z979	Cerebral spinal fluid circulation	98.00	40.00	19.60
Z066/Z963	Brain scan	68.90	24.70	13.10

NUCLEAR MEDICINE — IN VIVO

Code	**Respiratory System**	T $	P_1 $	P_2 $
Z071/Z967	Lung scan	68.90	25.75	10.50
Z059/Z968	— ventilation and perfusion on same day	103.40	39.10	19.20
	Miscellaneous			
Z091/Z980	Lymphangiogram	68.90	24.10	11.80
Z072/Z969	Ocular tumour localization	49.00	41.35	7.10
Z087/Z976	Tear duct — unilateral	61.20	17.95	8.80
Z085/Z989	— bilateral	68.90	21.50	10.50
Z033/Z986	Whole body counting	—	14.95	7.30

CLINICAL PROCEDURES ASSOCIATED WITH DIAGNOSTIC NUCLEAR MEDICINE PROCEDURES

Such procedural benefits are intended for the professional service of placing an instrument or introducing diagnostic radiopharmaceuticals. They are not intended to be used for simple subcutaneous, intramuscular or intravenous injection nor for oral administration. Rather than double listing the procedures and benefits in this part of the schedule, physicians are directed to the following reference points in the schedule.

(a) Intravenous injection for peripheral venography — G376 or G379 on page 98.

(b) Intra-articular injections — G370 on page 97.

(c) Injection into CSF spaces or shunt apparatus — Z821 on page 215.

(d) Arterial puncture — G479 on page 89.

(e) Paracentesis in conjunction with shunt patency study-Z590 on page 187.

NUCLEAR MEDICINE — IN VITRO (See Radioassays under Laboratory Medicine)

RADIATION ONCOLOGY (THERAPEUTIC RADIOLOGY)

Code	RADIOTHERAPY (including Therapeutic Isotopes)	$
	The listed benefits are for the professional services of a certified therapeutic radiologist, the services of a specialist for the intracavitary or interstitial application of radium or sealed sources and the services of a specialist using non-sealed sources of radioisotopes in a laboratory authorized by the Atomic Energy Control Board of Canada. Other medical services to the patient are not included in these figures. The cost of material is additional.	
	TELERADIOTHERAPY	
Note:	Paid only to a certified therapeutic radiologist, (Spec. code 34). The fee for all inpatient services is a hospital charge.	
X301	Major treatment planning (150 KVP or higher), dosage calculation and preparation of any special treatment device	42.10
X302	Teleradiotherapy — x-ray, 151 KVP or higher, radium, cobalt, cesium betatron linear accelerator — charge per treatment visit	10.70
X304	Minor teleradiotherapy — x-ray, 150 KVP or less — charge per treatment visit	7.10
Note:	For minor teleradiotherapy administered by other than certified therapeutic radiologists, use the listing under Diagnostic and Therapeutic Procedures.	
	RADIUM AND RADIOISOTOPES (sealed sources)	
X322	Treatment planning, dosage calculation and preparation of any special treatment device	42.10
	Intracavitary application of radium or sealed sources including dilatation and curettage carried out at same time as application	
X323	—first application	123.60
X334	—repeat application within 30 days	61.80
X324	Interstitial application of radium or sealed radioisotope	123.60
X325	Application of radium or radioisotope plaque or mould	38.30

RADIATION ONCOLOGY (THERAPEUTIC RADIOLOGY)

Code	RADIOISOTOPES (non-sealed sources)	$
Note:	The following benefits include treatment planning, dosage calculation and preparation of materials. Appropriate visit and procedural benefits (e.g. paracentesis) may be claimed in addition. Thyroid benefits (X326, X327, X335) include administrations within any three month period.	
X326	Thyroid malignancy	55.50
X336	Prostate malignancy	50.50
X327	Hyperthyroidism	50.50
X335	Induction of hypothyroidism	50.50
X328	Polycythaemia	29.50
X329	Metastatic disease of bone	45.90
X330	Ascites and/or pleural effusion(s) due to malignancy	36.00
X332	Arthritis — single or multiple site	23.75
X333	Metastatic disease with radioactive lymphogram	36.00

DIAGNOSTIC RADIOLOGY

Column T — The benefit for radiological examination including the production of radiographs, supplying of contrast media, apparatus; premises, technical services, administration and collection costs.

Column P — The benefit for consultation between radiologist and referring physician, fluoroscopy, interpretation of radiographs and fluoroscopic findings and supervision of x-ray services by a radiologist.

From 1980 to 1982 OHIP paid a surcharge on the technical fees to private radiology clinics in recognition of the increase in film cost.

Hospital out-patient technical fees will be paid at 94.17% of the technical fee listed in the Schedule of Benefits.

Notes and Interpretations:

1. Private offices and hospital outpatient departments will claim the sum of Columns T plus P.

2. Radiologists should use Column P as a guideline for negotiating remuneration with hospitals.

3. Benefits for clinical procedures related to x-ray examination are listed in the following section, or under Diagnostic and Therapeutic or Surgical Procedures. "Clinical Procedures", in this context, are those by which contrast media are introduced, except oral or rectal administration for study of the alimentary tract, and intravenous injections, which are an integral part of the study, performed by the physician collecting the benefit for the procedure.

4. If less than the minimum number of views are performed, reduce listed benefits by 25% (this reduction applies to both technical and professional component). If more than the minimum number of views are performed, no further benefit is applicable unless specifically listed.

5. If the examinations which are requested by the referring physician yield abnormal findings or if they would yield information which in the opinion of the radiologist would be insufficient, governed by the needs of the patient and the requirements of the referring physician, the radiologist may add further views and claim for them (if listed).

6. Claims for X-ray services, when referred by an Osteopath, Chiropodist or Chiropractor to a private X-ray facility are not benefits of O.H.I.P.

7. Claims for X-ray services, when referred by an Osteopath or Chiropractor to a hospital outpatient department are benefits.

8. Coding
   - —When coding the total benefit use suffix A.
   - —When coding the technical portion only use suffix B.
   - —When coding the professional portion only use suffix C.
   - —When coding claims from certified radiologists (33) use the listed codes (i.e. X001-X230) plus the appropriate suffix.
   - —When coding claims from non-certified radiologists increase the first numerical digit in the listed codes by 5 (i.e. X501-X730) plus the appropriate suffix.

9. When a radiologist is asked to x-ray one extremity only, no additional claim should be made for comparison x-rays initiated by the radiologist.

10. Nephrotomography is covered by the listings for intravenous pyelogram and planigram.

11. A stereo pair is to be counted as two views.

DIAGNOSTIC RADIOLOGY

12. No extra claim should be made for rapid sequence I.V.P.

13. No additional claim is warranted for the use of the image intensifier in diagnostic radiology.

14. Fluoroscopy claims should not be submitted for any examination performed by the radiologist where "fluoroscopy" is generally regarded as an integral part of the examination, e.g. examinations of the G.I. tract, urinary tract, special procedures.

15. "Colon — air contrast" may be claimed when performed according to generally accepted criteria. The colon should be scrupulously prepared. Five to eight full size views of the abdomen should be obtained after fluoroscopically controlled introduction of air and barium.

16. "Oesophagus, stomach and duodenum, double contrast" presupposes the introduction of gas, the use of antifoam agent and a suitable barium mixture.

17. Abdomen and chest studies should not be routinely done and claimed in gastrointestinal examinations.

18. Three or more views of the chest should not be done routinely and claimed when a chest examination is requested.

19. Chest studies should not be routinely done and claimed in mammography cases.

20. Nasal bones or accessory nasal sinuses should not be routinely claimed in skull examination requests.

21. Abdomen and/or pelvis should not be routinely claimed in lumbar spine examination requests.

22. A survey film of the abdomen is a single view. The ordering of additional films should be left to the discretion of the radiologist who should determine which examination is adequate for a specific patient. Obviously, if progress of a long tube is being followed, a survey film is sufficient. If, however, an intestinal obstruction is being followed, a single film is usually inadequate.

23. Conventional films of the spine should not be routinely done and claimed before myelography. The necessity of having plain film studies of the spine prior to interpreting the myelographic studies is obvious. It is not essential, however, that these be done at the institution where the myelogram was done. If they had been done at an outside office, then it is a matter for the radiologist and the referring physician to have the films available. If they cannot be made available to the radiologist, it is an acceptable practice for him to do the required examination of these areas and to claim for them so that they may be available for interpretation along with the myelographic study.

24. Pharynx and oesophagus (cine or videotape) — X106 should not be claimed routinely with X108 and X109 but only when specifically indicated.

25. Lumbar or lumbosacral spine (X028,) does not include the entire sacrum. However, an examination of the sacrum may be carried out and claimed only when specifically indicated.

26. A maximum of two computed tomography examinations per patient, per day, may be claimed.

27. The listed benefits apply to unilateral examinations except for central structures or as otherwise specified.

DIAGNOSTIC RADIOLOGY

		T		P	
		Spec.	Non Spec.	Spec.	Non Spec.
Code	**HEAD AND NECK**	$	$	$	$
X001	Skull — four views	24.50	18.35	8.00	6.00
X009	— five or more views	30.60	23.00	9.90	7.50
X003	Sella Turcica (when skull not examined)	12.20	9.20	3.90	2.90
X004	Facial bones — minimum of three views	17.85	13.40	6.30	4.75
X005	Nose — minimum of two views	12.20	9.20	3.90	2.90
	Mandible (Uni or bilateral) (not to be charged with X007)				
X006	— Minimum of three views	17.85	13.40	6.30	4.75
X012	— Four or more views	24.50	18.35	8.00	6.00
	Temporomandibular joints (not to be charged with X006 or X012)				
X007	— minimum of four views including open and closed mouth views	17.85	13.40	6.30	4.75
X008	Sinuses — minimum of three views	17.85	13.40	6.30	4.75
X010	Mastoids — bilateral — minimum of six views	23.60	17.70	8.80	6.60
X011	Internal auditory meati (when skull not examined)	17.85	13.40	6.30	4.75
N.C.	Teeth, up to ¼ set	N.A.B.	N.A.B.	N.A.B.	N.A.B.
N.C.	Teeth, up to ½ set	N.A.B.	N.A.B.	N.A.B.	N.A.B.
N.C.	Teeth, full set	N.A.B.	N.A.B.	N.A.B.	N.A.B.
N.C.	Teeth, bite wing	N.A.B.	N.A.B.	N.A.B.	N.A.B.
X016	Eye, for foreign body	12.20	9.10	5.60	4.20
X017	Eye, for localization, additional	12.60	9.40	14.30	10.70
X018	Optic foramina	13.80	10.30	5.60	4.20
X019	Salivary gland region	11.30	8.40	4.80	3.60
X020	Neck for soft tissues — minimum of two views	11.30	8.40	4.80	3.60
	Spine and Pelvis				
X025	Cervical spine — two or three views	21.25	15.90	4.80	3.60
X202	— four or five views	27.40	20.50	6.50	4.90
X203	— six or more views	33.20	24.90	7.90	6.00
X027	Thoracic spine — two views	19.50	14.60	4.80	3.60
X204	— three or more views	25.50	19.20	6.40	4.75
	Lumbar or lumbosacral spine				
X028	— two or three views	21.25	15.90	4.80	3.60
X205	— four or more views	27.40	20.50	6.50	4.90
X206	— six or more views	33.20	24.90	8.00	6.60
X032	Entire spine — (scoliosis series) minimum of four views	44.00	33.05	12.60	9.40
	— Orthoroentgenogram (3 foot film)				
X033	— Single view	17.85	13.40	6.30	4.75
X031	— Two or more views	24.50	18.35	7.90	5.90
X034	Sacrum and/or coccyx — two views	20.50	15.40	3.90	2.90
X207	— three or more views	25.50	19.20	6.40	4.80
X035	Sacro-iliac joints — two or three views	17.85	13.40	6.30	4.75
X208	— four or more views	23.80	17.85	7.90	5.90

DIAGNOSTIC RADIOLOGY

				T	P
		Spec.	Non Spec.	Spec.	Non Spec.
Code	**Spine and Pelvis - Cont'd**	$	$	$	$
X036	Pelvis and/or hips — one view	12.20	9.20	3.90	2.90
X037	— two views (e.g. A.P. and frog view; both hips; A.P. both hips plus lateral one hip)	22.80	17.10	5.50	4.20
X038	— three or more views (e.g. pelvis and sacro-iliac joints; A.P. both hips plus lateral each hip)	26.20	19.60	6.30	4.75
	Upper Extremities				
X045	Clavicle — two views	12.20	9.20	3.90	2.90
X209	— three or more views	18.80	14.10	5.50	4.10
	Acromioclavicular joints (bilateral) with or without weighted distraction				
X046	— two views	17.85	13.40	6.30	4.75
X210	— three or more views	24.40	18.30	7.90	5.90
	Sternoclavicular joints — (bilateral)				
X047	— two or three views	14.70	11.00	4.80	3.60
X211	— four or more views	21.10	15.90	6.40	4.80
X048	Shoulder — two views	14.70	11.00	4.80	3.60
X212	— three or more views	21.10	15.90	6.40	4.80
X049	Scapula — two views	14.70	11.00	4.80	3.60
X213	— three or more views	21.10	15.90	6.40	4.80
	Humerus — including one joint				
X050	— two views	12.20	9.20	3.90	2.90
X214	— three or more views	18.80	14.10	5.50	4.10
X051	Elbow — two views	12.20	9.20	3.90	2.90
X215	— three or four views	18.80	14.10	5.50	4.10
X216	— five or more views	25.40	19.00	7.10	5.30
	Forearm — including one joint				
X052	— two views	12.20	9.20	3.90	2.90
X217	— three or more views	18.80	14.10	5.50	4.10
X053	Wrist — two or three views	12.20	9.20	3.90	2.90
X218	— four or more views	18.80	14.10	5.50	4.10
X054	Hand — two or three views	12.20	9.20	3.90	2.90
X219	— four or more views	18.80	14.10	5.50	4.10
X055	Wrist and hand — three views	17.85	13.40	7.90	5.90
X220	— four or more views	22.70	17.00	9.40	7.10
X056	Finger or thumb — two views	9.40	7.10	2.80	2.10
X221	— three or more views	12.20	9.20	3.90	2.90
	LOWER EXTREMITIES				
X060	Hip — unilateral — two or more views	19.50	14.60	4.80	3.60
	Femur — including one joint				
X063	— two views	12.20	9.20	3.90	2.90
X223	— three or more views	18.80	14.10	5.50	4.10
	Knee (including patella)				
X065	— two views	12.20	9.20	3.90	2.90
X224	— three or four views	18.80	14.10	5.50	4.10
X225	— five or more views	26.40	19.00	7.10	5.30

DIAGNOSTIC RADIOLOGY

		T		P	
		Spec.	Non Spec.	Spec.	Non Spec.
Code	**LOWER EXTREMITIES - Cont'd**	$	$	$	$
	Tibia and fibula (including one joint)				
X066	— two views	12.20	9.20	3.90	2.90
X226	— three or more views	18.80	14.10	5.50	4.10
X067	Ankle — three views	12.20	9.20	3.90	2.90
X227	— four or more views	18.80	14.10	5.50	4.10
X068	Calcaneus — two views	12.20	9.20	3.90	2.90
X228	— three or more views	18.80	14.10	5.50	4.10
X069	Foot — three views	12.20	9.20	3.90	2.90
X229	— four or more views	18.80	14.10	5.50	4.10
X072	Toe — two views	9.40	7.10	2.75	2.10
X230	— three or more views	12.20	9.20	3.90	2.90
X064	Leg length studies (Orthoroentgenogram)	17.85	13.40	6.30	4.75
	Skeletal Surveys				
	Skeletal survey for bone age				
X057	— single film	12.20	9.20	3.90	2.90
X058	— two or more films or views	18.00	13.45	6.40	4.75
	Other survey studies — e.g., rheumatoid, metabolic or metastatic				
X080	— basic	6.10	4.50	2.00	1.50
X081	— plus per film or view	6.10	4.50	2.00	1.50
	Chest				
N.C.	Miniature chest film — for survey purposes only	N.A.B.	N.A.B	N.A.B.	N.A.B.
X090	Single film (see Interpretation #17)	12.20	9.20	3.90	2.90
X091	Two views	18.00	13.45	6.40	4.75
X092	Three or more views	23.10	17.40	7.60	5.65
X039	Ribs (unilateral) — two or more views	14.70	11.00	4.80	3.60
X040	Sternum — two or more views	14.70	11.00	4.80	3.60
X096	Thoracic inlet — two or more views	12.20	9.20	3.90	2.90
	Abdomen				
X100	Single view (See Interpretation #17)	12.20	9.20	3.90	2.90
X101	Two or more views	18.70	14.05	5.50	4.20
	G.I. Tract				
X105	Palatopharyngeal analysis (cine or videotape)	24.25	18.20	15.80	11.90
X106	Pharynx and oesophagus (cine or videotape)	24.25	18.20	15.80	11.90
Note:	X106 may not be claimed with X107. It may be claimed with X104, X108, X109 only when specifically indicated. See Interpretation #24.				
X107	Oesophagus — when X103, X104, X108 or X109 not claimed	22.00	16.45	10.20	7.65
X108	Oesophagus, stomach and duodenum (including survey film, if taken)	38.10	28.60	18.35	13.80

DIAGNOSTIC RADIOLOGY

Code				T	P
			Non		Non
		Spec.	Spec.	Spec.	Spec.
		$	$	$	$
	G.I. Tract - Cont'd				
X104	Oesophagus, stomach and duodenum (including survey film, if taken) — double contrast	39.70	29.80	20.10	15.10
X103	Oesophagus, stomach and duodenum (including survey film, if taken) — double contrast, plus small bowel	50.15	37.60	25.50	19.10
X109	Oesophagus, stomach and small bowel	48.60	36.40	23.75	17.80
X110	Hypotonic duodenogram	32.40	24.30	15.80	11.90
X111	Small bowel only	22.00	16.45	10.20	7.65
X112	Colon — barium enema (including survey film, if taken)	39.70	29.80	16.70	12.50
X113	Colon — air contrast, primary or secondary, including survey film if taken	50.20	37.60	21.60	16.20
X114	Gallbladder (one or multiple day examinations)	24.50	18.35	8.00	6.00
X120	Gallbladder (one or multiple day examinations with preliminary plain film)	32.70	24.50	8.00	6.00
X116	T-Tube cholangiogram	17.85	13.40	6.30	4.75
X117	Operative cholangiogram	17.85	13.40	6.30	4.75
X118	Intravenous cholangiogram	40.70	30.50	14.30	10.70
X123	Operative pancreatogram or E.R.C.P.	17.85	13.40	6.30	4.75
	G.U. Tract				
X129	Retrograde pyelogram (uni or bilateral)	17.85	13.40	6.30	4.75
X130	Intravenous pyelogram including preliminary film	40.70	30.60	15.90	11.90
X137	Cystogram (catheter)	19.60	14.70	4.80	3.60
X135	Cystourethrogram, stress or voiding (catheter)	22.70	17.00	9.50	7.10
X131	Cystourethrogram (non-catheter)	4.80	3.60	3.20	2.40
X191	Intestinal conduit examination or nephrostogram	17.85	13.40	6.30	4.75
X138	Percutaneous antegrade pyelogram	17.85	13.40	6.30	4.75
X139	Percutaneous nephrostomy	17.85	13.40	6.30	4.75
X134	Urethrogram (retrograde)	14.70	11.00	4.80	3.60
X136	Vasogram	14.70	11.00	4.80	3.60
	Obstetrics and Gynaecology				
X143	Survey film	12.20	9.20	3.90	2.90
X144	Pelvimetry	17.85	13.40	6.30	4.75
X145	Placentogram	17.85	13.40	6.30	4.75
X146	Any combination of above	30.80	23.10	9.50	7.10
X147	Hysterosalpingogram	24.50	18.35	7.90	5.90
X148	Intra-uterine foetal transfusion — radiological control	32.40	24.30	15.80	11.90
	Fluoroscopy — by physician with or without spotfilms				
X195	Chest	7.65	5.70	7.90	5.90
X196	Skeleton	7.65	5.70	7.90	5.90
X197	Abdomen	7.65	5.70	7.90	5.90
X189	Fluoroscopic control of clinical procedures done by another physician per ¼ hour	6.10	4.50	13.30	9.90

DIAGNOSTIC RADIOLOGY

		T		P	
		Spec.	Non Spec.	Spec.	Non Spec.
Code	**Fluoroscopy - Cont'd**	$	$	$	$
	Special Examinations				
X155	Abdominal or pelvic pneumogram	32.80	24.60	7.90	5.90
	Angiography				
	— by catheterization				
	— abdominal, thoracic, cervical or cranial				
	— using single films				
X179	non-selective	24.50	18.35	7.90	5.90
X180	selective (per vessel to a max. of 4)	32.40	24.30	15.80	11.90
	— using film changer, Cine **or multiformat camera**				
X181	non-selective	49.00	36.70	15.80	11.90
X182	selective (per vessel to a max. of 4)	65.20	48.90	23.75	17.80
X140	**selective (6 or more vessels)**	**I.C.**	**I.C.**	**I.C.**	**I.C.**
	Carotid angiogram — direct puncture				
X160	— unilateral	40.20	30.15	23.75	17.80
X161	— bilateral	64.60	48.50	35.70	26.80
	Peripheral angiogram				
X174	— unilateral	24.50	18.35	7.90	5.90
X175	— bilateral	32.40	24.30	15.80	11.90
X198	Splenoportogram	48.60	36.40	15.80	11.90
X199	Translumbar aortogram	48.60	36.40	15.80	11.90
	Vertebral angiogram — direct puncture or retrograde brachial injection				
X132	— unilateral	40.20	30.15	23.75	17.80
X133	— bilateral	65.75	49.30	35.70	26.80
X156	Arthrogram	21.60	16.20	17.45	13.10
X200	— with fluoroscopy and complete positioning throughout by physician	30.30	22.70	25.40	19.10
X157	Bone density (mineral content) measurement	27.50	18.35	12.60	9.40
X158	Bronchogram — unilateral	24.10	18.10	15.80	11.90
X159	— bilateral	32.05	24.00	23.75	17.80
X162	Cerebral stereotaxis	49.00	36.70	15.80	11.90
X122	Cholangiogram, percutaneous trans-hepatic	24.30	18.20	11.90	8.90
X188	**Computed tomography — head**	—	—	50.30	—
X124	**— neck**	—	—	50.30	—
X125	**— thorax**	—	—	50.30	—
X126	**— abdomen**	—	—	50.30	—
X127	**— extremities**	—	—	50.30	—
X151	Cordotomy, percutaneous	40.20	30.15	23.75	17.80
X163	Dacrocystogram	24.50	18.35	7.90	5.90
X164	Discogram(s) — one or more levels	24.10	18.10	15.80	11.90
X167	Fistula or sinus injection	17.85	13.40	6.30	4.75
X169	Laminogram, planigram, tomogram	32.80	24.60	7.90	5.90
X170	Laryngogram	24.10	18.10	15.80	11.90

DIAGNOSTIC RADIOLOGY

				T	P
		Spec.	Non Spec.	Spec.	Non Spec.
Code	**Special Examinations - Cont'd**	$	$	$	$
X171	Lymphangiogram	40.70	30.50	15.80	11.90
X192	Mammary ductography	17.85	13.40	6.30	4.75
X184	Mammogram — unilateral	20.40	15.30	8.70	6.50
X185	— bilateral	30.30	22.70	13.10	9.80
	— using xeroradiography				
X186	— unilateral	25.20	18.85	8.70	6.50
X187	— bilateral	38.70	29.00	13.10	9.80
X150	Mechanical evaluation of knee	21.00	15.70	11.10	8.30
X193	Microradioscopy of the hands	12.05	9.00	7.90	5.90
X173	Myelogram (spine and/or posterior fossa)	28.80	21.60	19.10	14.30
X190	Pantomography	14.70	11.00	4.80	3.60
X154	Penis	13.20	9.90	3.20	2.40
X176	Sialogram	24.50	18.35	7.90	5.90
X177	Skin thickness measurement	12.90	9.70	6.30	4.75
X183	Ventriculogram or pneumoencephalogram	40.20	30.15	23.75	17.80
X165	Photographic subtraction	—	—	7.90	—
X166	Examination using portable machine in home add	51.80	51.80	—	—

Note: This code does not apply to the use of a portable machine in a hospital. Can only be claimed once per day regardless of the number of people x-rayed in the same home.

CLINICAL PROCEDURES ASSOCIATED WITH DIAGNOSTIC RADIOLOGICAL EXAMINATIONS

Note:

1. These procedural benefits are intended to cover compensation for the professional service of placing an instrument and, if done, of introducing contrast media (except oral or rectal administration for study of the alimentary tract). Injection of materials to enhance the effect of contrast media is included in the procedure benefits.
2. Radiological charges are additional: see similar entries under section on RADIOLOGY.
3. Where similar procedures are done for diagnostic physiological studies of non-radiological nature, e.g. cardiac catheterization or intra-arterial infusion, they are listed separately under Surgery or Diagnostic and Therapeutic Procedures. See Index.

Code	Angiography	Spec. $	Anaes.
	— by catheterization		
	— abdominal, thoracic, cervical or cranial		
J021	Insertion of catheter (including cut down if necessary) and injection, if given	73.40	5
J022	Selective catheterization — add to catheter insertion benefit (per vessel to maximum of four) each	36.70	
Note:	J021 includes insertion to any distance along vessel and its extensions. J022 applies only when selected branches are catheterized.		
J014	Selective catheterization (spinal and parathyroid angiography — add to benefit for catheter insertion (per vessel) each	18.35	
	("Selective" means manipulation of the catheter from the vessel of introduction into a branch, tributary, or cardiac chamber with angiogram(s))		
J031	Carotid angiogram — direct puncture	58.50	5
J025	Transluminal angioplasty — including angioplasty with or without pressure measurements — one or more sites or vessels	191.30	5
J048	Percutaneous trans-hepatic catheter portal venography	149.20	
J027	Peripheral arteriogram — direct puncture	36.70	4
J026	Peripheral venogram — direct puncture	29.50	4
	Selective coronary catheterization including angiogram — see G293, G297 on pages 89, 90.		
J033	Splenoportogram	58.50	4
J034	Trans-lumbar aortogram	58.50	4
J032	Vertebral angiogram — direct puncture or by retrograde brachial injection	58.50	5

CLINICAL PROCEDURES ASSOCIATED WITH DIAGNOSTIC RADIOLOGICAL EXAMINATIONS

Code		Spec. $	Anaes.
	Embolization e.g. for treatment of hemangioma or renal — 8carcinoma		
J040	— first vessel, claim appropriate angiographic procedural and radiological benefits plus	50.50	
J047	— each additional vessel catheterized and occluded, per vessel	23.70	
J023	Intra-arterial infusion of drugs e.g. for control of gastrointestinal haemorrhage — claim appropriate angiographic procedural and radiological benefits plus a per diem supervision benefit of	14.20	
J035	Pressure measurements during angiography	14.20	
J001	Arthrogram	14.20	4
	Biliary duct calculus manipulation etc. — see Z562 on page 185.		
J024	Bronchial brushing — unilateral	58.50	6
J044	— bilateral	87.80	6
J002	Bronchogram — unilateral	17.60	6
J043	— bilateral	26.40	6
J003	Bronchogram with intra-tracheal catheter — unilateral	35.80	6
J042	— bilateral	53.55	6
J050	Carotid or vertebral artery occlusion by detachable balloon — percutaneous	160.70	
J005	Dacrocystogram	21.80	4
J006	Discogram — one disc	50.50	4
J030	— each additional disc	26.00	
J049	Embolization of spinal arteriovenous malformation — percutaneous	229.60	
J036	Fistula or sinus injection	14.20	
J008	Hysterosalpingogram	29.50	4
J004	Intramammary needling for localization under mammographic control	21.80	
	Intubation of small intestine — see Z540 on page 181.		
J009	Laryngogram	17.60	
J010	Lymphangiogram — per side	50.50	
J037	Mammary ductography	21.80	
J011	Myelogram	50.50	4
J038	— with supine views requiring removal and re-introduction of spinal needle, add	14.20	
J020	— with posterior fossa views, add	14.20	
J012	Nephrotomogram	—	4
J045	Percutaneous antegrade pyelogram	58.50	4
J046	Percutaneous nephrostomy	107.10	4
J041	Percutaneous removal of intravascular foreign bodies	I.C.	I.C.
J051	Percutaneous spinal cord puncture for syringogram	49.70	4
J013	Percutaneous trans-hepatic cholangiogram	50.50	4
J015	Peritoneal pneumogram	21.80	4
J016	Pneumoencephalogram	65.00	5
J052	Positive contrast cisternogram	65.00	4

CLINICAL PROCEDURES ASSOCIATED WITH DIAGNOSTIC RADIOLOGICAL EXAMINATIONS

Code		Spec.	Anaes.
		$	
J017	Presacral insufflation	36.70	4
J039	Renal cyst puncture	58.50	4
J018	Sialogram	21.80	4
J007	Tomogram	—	4
J028	Urethrogram, urethrocystogram, or intestinal conduit examination, nephrostogram, cystogram	14.20	
J029	Vasogram	39.00	4

PULMONARY FUNCTION STUDIES

Column T — The benefit for testing including supplying of equipment, premises and technical services.

Column P — The benefit for professional services including responsibility for quality control and technician training, interpretation of the results of the tests, and consultation between the physician responsible for the tests and the referring physician concerning the results of the tests.

Notes: (1) The total benefit is obtained by adding columns T and P together.

(2) Coding: When coding the total benefit, use suffix A.
When coding the technical portion only, use suffix B.
When coding the professional portion only, use suffix C.

(3) The benefits for **J301, J324, J325, J326, J304 and J327** represent the best of three recorded tests results with or without bronchodilator.

(4) The following tests are considered to be specific and require individual ordering notation for each test parameter.

(5) Vital capacity and flow volume loop cannot be claimed at the same time.

Code		T	P
		$	$
	Any spirometric assessment made without permanent record (V.C, FEV, MVV, etc.)		
J301	Vital capacity, Fev$_1$, FEV$_1$/FVC	9.30	4.90
J324	Repeat **J301** after bronchodilator	1.90	2.00
J325	Same as **J301** plus MMEFR (**FEF 25-75**) calculation	9.65	7.00
J326	Repeat **J325** after bronchodilator	1.90	2.00
	J301 and **J325** cannot be billed together **J324** and **J326** cannot be billed together		
J304	Flow volume loop (FVC, FEV$_1$, FEV$_1$/FVC, V$_{50}$, V$_{25}$)	13.90	9.90
J327	Repeat **J304** after bronchodilator	1.90	2.00
J311	Functional residual capacity by gas dilution method	12.10	10.70
J307	Functional residual capacity by body plethysmography	13.00	10.90
J305	Lung compliance (pressure volume curve of the lung from TLC to FRC)	38.70	32.80
J306	Airways resistance by plethysmography or estimated using esophageal catheter	12.00	9.80
J309	Carbon monoxide diffusing capacity by steady state at rest	8.30	6.30
J310	**Carbon monoxide diffusing capacity by single breath**	16.00	11.00
	Pulmonary Function Response to O$_2$ and CO$_2$		
J308	**Carbon monoxide** ventilatory response	14.90	9.90
J328	**Oxygen** ventilatory response (physician must be present)	14.90	14.90

PULMONARY FUNCTION STUDIES

Code		T	P
		$	$
	Exercise Assessment — physician must be in attendance at all times.		
J315	Stage I: Graded exercise to maximum tolerance exercise (must include continuous heart rate and ventilation at rest and at each workload)	37.00	24.70
E450	**J315 plus J301, J325 or J304** before and/or after exercise, add	9.90	5.00
E451	**J315** plus 12 lead E.C.G. done at rest, used for monitoring during the exercise and followed for at least 5 minutes post exercise, add	13.45	15.60
J316	Stage II: Repeated steady state graded exercise (must include heart rate, ventilation, VO_2, VCO_2, BP, ECG, end tidal and mixed venous CO_2, at rest, 3 levels of exercise and recovery)	97.50	45.70
J317	Stage III: **E451** plus arterial blood gases, PH and bicarbonate or lactate	129.30	77.60
J330	**Assessment of exercise induced asthma workload sufficient to achieve heart rate 85% of predicted maximum; performance of J301, J325 or J304 before exercise and 5-10 minutes post exercise**	24.80	14.90
G479	Arterial puncture for blood gas analysis	—	6.30
J319	Blood gas analysis: pH, PO_2, PCO_2, bicarbonate and base excess	8.40	—
J318	Arterialized venous blood sample collection (e.g. ear lobe)	2.80	—
J320	A-a oxygen gradient (measurement of RQ by sampling mixed expired gas and using alveolar air equation)	15.40	7.90
J331	Estimate of **shunt** (Qs/Qt) breathing pure oxygen	20.50	10.30
J313	Mixed venous PCO_2 by the rebreathing method	8.40	2.80
J323	O_2 saturation by oximeter (at rest)	8.00	4.00
J332	same as **J323** with measurements at rest and exercise	12.10	6.10
J322	Standard O_2 consumption and CO_2 production	20.50	5.15
J333	Histamine or methylcholine threshold test	28.80	21.10
J335	Antigen challenge test	39.70	20.00
	Sleep Apnea (Overnight) Study with		
J339	Monitoring of oxygen saturation and ventilation for a period of sleep time. to include physician attendance at set-up, monitoring and interpretation	—	92.30
J336	interpretation only	—	34.30
	Same as **J339**, with additional monitoring such as to allow the staging of sleep, e.g., EEG, EOG, **add to J339 when both performed**		
J337	to include physician attendance at set-up, monitoring, and interpretation, add to J339 when performed	—	34.30
J338	interpretation **of J337 only**, add to J336 when **both** performed	—	14.30

DIAGNOSTIC ULTRASOUND

Notes:

(1) T and P Columns should be interpreted in the spirit of the first two paragraphs on page 65, but without limiting the performance of these tests to physicians of any one specialty.

(2) The total benefit is obtained by adding columns T and P together.

(3) Coding: When coding the total benefit, use suffix A.
When coding the technical portion only, use suffix B.
When coding the professional portion only, use suffix C.

(4) A-Mode — implies a one-dimensional ultrasonic measurement procedure.

(5) M-Mode — implies a one-dimensional ultrasonic measurement procedure with movement of the trace to record amplitude and velocity of moving echo-producing structures.

(6) Scan B-Mode — implies a two-dimensional ultrasonic scanning procedure with a two-dimensional display.

(7) All ultrasound examinations include a permanent record and **interpretive report.**

Code		T	P
	Head and Neck	$	$
J100	Echoencephalography-midline, A-mode	—	3.60
J122	Brain — complete, B-mode	36.60	21.00
	Echography-ophthalmic (excluding vascular study)		
J102	Quantitive, A-mode	19.10	27.90
J103	B-scan immersion	37.50	37.10
J107	B-scan contact	19.00	18.40
J108	Biometry (Axial length-A-mode)	18.70	24.90
Note:	J102, J103, J107, J108 — for bilateral procedures, add 50% of the listed benefit.		
J105	Face and/or neck (excluding vascular study)	36.60	21.00
	Heart		
	Echocardiography — complete study		
J118	— 1 dimension	27.50	27.50
J120	— 2 dimensions (real time)	47.20	43.30
J121	— 1 and 2 dimensions at same patient visit	60.60	57.40
J119	— limited study — 1 or 2 dimensions for follow up studies **not to be charged in conjunction with pregnancy study**	13.05	13.05
J109	**Saline study (including venipuncture)**	—	8.60
	Thorax		
J125	Chest masses, pleural effusion-A & B-mode	36.60	21.00

DIAGNOSTIC ULTRASOUND

		T	P
Code		$	$
	Abdomen and Retroperitoneum		
J135	Abdominal scan, complete	36.60	21.00
J128	Abdominal scan, limited study (e.g. gallbladder only, aorta only or follow up study)	24.10	13.95
	Pelvis		
J159	Pregnancy, complete	36.60	21.00
J162	Pelvic, complete	36.60	21.00
J163	Pelvis or pregnancy, limited study (e.g. fetal age determination, placental localization I.U.C.D. localization only)	24.10	13.95
	Vascular System		
J190	Bilateral carotid artery evaluation — Doppler scan or B scan	34.20	19.70
J191	— frequency analysis	34.20	19.70
J192	— frequency analysis with scan	34.20	19.70
	Peripheral artery evaluation (including vertebral and subclavian arteries)		
J193	— Doppler scan or B scan	17.10	13.00
J194	— frequency analysis	11.40	10.70
J195	— frequency analysis with scan	24.20	20.20
J198	Venous assessment (bilateral) — includes assessment of femoral, popliteal and posterior or tibial veins with appropriate functional manouvres and permanent record (not chargeable during surgery or during the patient's post operative stay in hospital)	5.70	8.80
	Vascular laboratory fees		
J199	Ankle pressure determination — not chargeable during surgery or during the patient's post operative stay in hospital	—	6.90
J200	Ankle pressure measurements with segmental pressure recordings and/or pulse volume recordings and/or Doppler recordings	15.80	19.40
J196	Ankle pressure measurements with exercise and/or quantitative measurements added to the above	6.15	9.15
J197	Penile pressure recordings — two or more pressures	5.40	6.90
	Miscellaneous		
J180	Echography for placement of radiation therapy fields, scan B-mode	27.20	16.70
J182	Extremities — per limb (excluding vascular study)	18.20	10.60
J127	Breast — scan B-mode (per breast)	18.20	10.60
J183	Testicular scan — per testis	18.20	10.60
J149	Ultrasonic guidance of biopsy aspiration, ammiocentesis or drainage procedures (one physician only)	36.60	21.00

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Code With a few exceptions specifically indicated below, the listed procedural benefits are for the procedure(s) alone.

Consultations or visits when such services are rendered, may be claimed in addition to the procedure(s).

G700 When a procedure(s) is the sole reason for a visit, add $3.60 per patient visit for those procedures marked (+) regardless of the number of procedures carried out during that visit. However, if the patient visit is to a physician's office or a diagnostic facility controlled directly or indirectly by a physician who has examined (or is about to examine) the patient and referred the patient to such a diagnostic facility, G700 may not be claimed under these circumstances.

Note: G700 is not payable to a hospital department.

Schedule Interpretations:

1. **Urinalysis and other diagnostic tests, listed on page 99 in the Diagnostic and Therapeutic Section of the Schedule of Benefits when performed by a physician, with or without an associated visit to the physician's office, should be claimed exclusively from these listings.**
Similar services listed in the Laboratory Medicine Section of the Schedule are to be claimed by licensed laboratories only.

2. Some benefits for Diagnostic and Therapeutic Procedures have the technical and professional components listed separately. However, when only one benefit is listed for a service, it represents the professional component only. The technical component includes the salaries of support staff, equipment depreciation or lease costs, supplies and costs associated with the preparation of a written report. The professional component includes the clinical supervision of the diagnostic facility, interpretation of the test results and a written report.

3. The Preamble applicable to Surgical Procedures also applies, where appropriate, to Diagnostic and Therapeutic Procedures.

ALLERGY

Note: If, in addition to the allergy injection, the patient requires a minor assessment only of his allergic condition, the physician may claim for code G212 only. However, if a patient requires a more complete assessment of his condition or if a patient presents for an allergy injection and has an acute infectious condition, albeit of the respiratory system, or some other unrelated condition any of which would have otherwise required a separate office visit, the physician is entitled to claim for the appropriate assessment as well as the injection.

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Code	ALLERGY	Procedural Fee $	Anaes.
+G200	Acute desensitization, e.g. ATS, penicillin	5.90	
+G201	Direct nasal tests, $1.10 each, maximum	3.30	
+G202	Hyposensitization, including assessment and supervision (one or more injections)	2.60	
Note:	Use this code for rabies injection(s).		
G212	If hyposensitization is the only service rendered, use this code. This code combines G700 and G202	6.20	
G205	Insect venom desensitization (immunotherapy) — per injection to a maximum of 5 per patient per day	8.80	
Note:	In addition to G205, after the initial major assessment, a minor or **partial** assessment may be claimed once per day if rendered.		
+G203	Ophthalmic tests — direct, $1.10 each, maximum	3.30	
+G204	— quantitative	8.60	
G206	Patch test $1.00 each, maximum of 35 per year	35.00	
G198	Maximum of 50 per year for industrial or occupational dermatoses	50.00	
+G207	Bronchial provocative testings — per session (limit of 6 sessions per patient)	9.55	
	Skin tests provided in physician's office or in hospital, including physician interpretation, (scratch or intradermal method)		
G209	— technical component $0.57 each, maximum	28.50	
G197	— professional component $0.08 each, maximum	4.00	
G199	Insect venom skin testing provided in physician's office or hospital including physician interpretation, $0.80 each, maximum	24.00	
G195	**Local anaesthetic hypersensitivity skin test, $0.70 each, maximum of 25 per year**	17.50	
G196	**Penicillin hypersensitivity skin test $0.70 each, maximum of 15 per year**	10.50	

ANAESTHESIA

Code		Procedural Fee $	Anaes.
	Examination Under Anaesthesia — when sole procedure performed not otherwise listed in the schedule (diagnosis required)		
G260	with or without intubation	34.30	4

CARDIOVASCULAR

Code		Procedural Fee $	Anaes.
	Vascular Cannulation (including injections and cut-down, if necessary)		
G268	Cannulation of artery or central vein e.g. for pressure measurement or for feeding line	21.00	
G309	Umbilical artery catheterization (including obtaining of blood sample)	30.80	
Note:	Use this code for Usher routine for acidosis (infant).		

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Code	CARDIOVASCULAR - Cont'd	Procedural Fee $	Anaes.
G282	Umbilical vein catheterization (including obtaining of blood sample)	13.40	
G287	Insertion of Swan-Ganz catheter (not included in anaesthetic, respiratory or critical care benefits)	110.20	4
G304	— when dye dilution densitometry done in addition at same sitting, add	34.30	
G398	Insertion of permanent feeding line e.g. Hickman or Broviac Catheter	91.90	4
G399	Surgical removal of Hickman or Broviac Catheter	26.80	4
G479	Arterial puncture	6.30	
+G480	Venipuncture — infant	6.30	
+G482	— child	4.20	
+G489	— adolescent or adult	1.50	
+G483	Therapeutic venisection (phlebotomy)	6.50	
G271	Anticoagulant supervision — long term, telephone advice — per month	7.15	
	Blood Transfusions:		
G279	Indirect transfusion	12.60	
G275	Exchange transfusion (procedure only)	138.10	
Note:	Assistant at exchange transfusion — see Preamble, Part B, Paragraph 35(b)		
G280	Intra-uterine foetal transfusion — initial or subsequent	126.30	
	Plasmapheresis (to include cannulation)		
G276	— donor cell pheresis (platelets or leukocytes)	10.40	
	— therapeutic plasma exchange		
G277	— initial and repeat, to a maximum of 5 per year, each	51.30	
G278	— beyond 5 per year, each	25.65	
G272	Manual plasmapheresis (see Preamble, part B, paragraph 24)	I.C.	
	Cardioversion:		
G285	Cardioversion — limit of three sessions per patient, per day	38.30	5
	Cardiac Catheterization:		
	When more than one procedure is carried out at one sitting, the additional procedures are to be claimed at 50% of the listed benefits.		
G290	— pressures only	103.70	5
	Left heart		
G291	— retrograde aortic	121.60	5
G292	— transseptal	171.70	5
G286	Cardiac electrophysiological studies (endomyocardial mapping) with timed pulse stress of conduction system to analyze arrhythmias	171.70	5
G293	Selective coronary catheterization — both arteries	168.10	5

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Code	CARDIOVASCULAR – Cont'd	Procedural Fee	Anaes.
		$	
G263	— with drug interventional studies, add	60.80	
G265	Transluminal coronary angioplasty including angiography with or without pressure measurements, **one or more sites or vessels**	250.40	5
G297	Angiograms (any number of injections)	75.10	
G296	Dye dilution densitometry and/or thermal dilution studies — coronary flow index benefit covers all studies on the same day	68.70	
Note:	When G296 is done in addition to G287, it may be claimed at 50% only. Use code G304 instead.		
G298	Intracardiac electrocardiography and/or atrial pacing	68.70	
G299	Oxymetry	68.70	
G289	Fick determination	68.70	
G300	Metabolic studies, e.g. coronary sinus lactate and pyruvate determinations	68.70	
G301	Exercise studies during catheterization	75.10	
G303	Intracardiac phonocardiography	75.10	
G306	Isotope studies during cardiac catheterization	68.70	
G267	HIS bundle ECG	114.50	
G266	HIS bundle ECG, timed pulse stress of conduction with drug intervention	153.80	
G294	Insertion of temporary endocardial electrode	103.70	5
G254	Repositioning of temporary endocardial electrode	42.90	5
G295	Insertion of permanent endocardial electrode and implantation of pack (includes insertion of temporary transvenous lead at same surgical procedure by same surgeon)	211.10	5
G269	Insertion of permanent endocardial electrode(s)	96.60	
G270	Exposure of vein and implantation of pack	110.90	5
G302	Repositioning of permanent endocardial electrode (as separate procedure)	80.10	5
G264	Replacement of pack	96.60	5
G288	Endomyocardial biopsy — transvascular, right or left	114.50	
G303	Insertion of transthoracic pacemaker	34.30	4
	Electrocardiography: (professional component must include pertinent written interpretation)		
+G310	E.C.G. — technical component	4.65	
G313	— professional component — practice in general	5.00	
G318	— professional component — specialist	6.80	
	Before and after exercise (Master's criteria, Levy Ischemia or Frasher Exercise test) includes complete resting tracing and multiple leads taken immediately and 3 and 6 minutes post exercise.		
G314	— technical component	7.50	
G334	— professional component	7.30	

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Code	CARDIOVASCULAR - Cont'd	Procedural Fee $	Anaes.
	Maximal stress E.C.G. (exhaustion, symptoms, or E.C.G. changes) or sub-maximal stress E.C.G. (to target heart rate for patient) by a standard technique — with treadmill or ergometer and oscilloscopic continuous monitoring including E.C.G.'s taken during the procedure and resting E.C.G.'s before and after the procedure (physician must be in attendance at all times) professional component includes the necessary clinical assessment immediately prior to testing		
G315	— technical component	24.30	
G319	— professional component	36.80	
G316	Vector — technical component	12.50	
G335	— professional component	6.80	
	Continuous ECG monitoring e.g. Holter		
	Level 1 — requires a recorder capable of recording all beats and transmitting this information to a scanner which is capable of analyzing and printing every beat and also performing trend analysis on the 12 or 24 hour tape.		
	Level 2 — requires a recorder capable of recording only a portion of each minute, or a predetermined time period after an abnormal complex is sensed. The scanner of this recorder is capable of analyzing the tape and printing all beats in the predetermined time period analyzing the ST segment, heart rate and ventricular premature beat frequency.		
	Level 3 — requires a recorder capable of recording beats for only a portion of a minute and feeding this information into a scanner through an adapter that feeds the information through the standard E.C.G. machine.		
G650	Level 1 — professional component	32.55	
G651	— technical component — recording	17.70	
G652	— **scanning**	24.30	
G653	Level 2 — professional component	23.60	
G654	— technical component — recording	17.20	
G655	— **scanning**	11.80	
G656	Level 3 — professional component	15.70	
G657	— technical component — recording	11.80	
G658	— scanning	7.90	
	Interpretation of telephone transmitted E.C.G. rhythm strip		
G320	— professional component must include pertinent written interpretation	2.90	
G311	— technical component for telephone transmission	1.40	
	Single chamber reprogramming including electrocardiography.		
G283	— professional component	6.40	
G284	— technical component	6.40	
	Dual chamber reprogramming including electrocardiography.		
G180	**— professional component**	**9.65**	
G181	**— technical component**	**8.60**	

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Code	CARDIOVASCULAR – Cont'd	Procedural Fee $	Anaes.
G263	— with drug interventional studies, add	60.80	
G265	Transluminal coronary angioplasty including angiography with or without pressure measurements, **one or more sites or vessels**	**250.40**	5
G297	Angiograms (any number of injections)	75.10	
G296	Dye dilution densitometry and/or thermal dilution studies — coronary flow index benefit covers all studies on the same day	68.70	
Note:	When G296 is done in addition to G287, it may be claimed at 50% only. Use code G304 instead.		
G298	Intracardiac electrocardiography and/or atrial pacing	68.70	
G299	Oxymetry	68.70	
G289	Fick determination	68.70	
G300	Metabolic studies, e.g. coronary sinus lactate and pyruvate determinations	68.70	
G301	Exercise studies during catheterization	75.10	
G305	Intracardiac phonocardiography	75.10	
G306	Isotope studies during cardiac catheterization	68.70	
G267	HIS bundle ECG	114.50	
G266	HIS bundle ECG, timed pulse stress of conduction with drug intervention	153.80	
G294	Insertion of temporary endocardial electrode	103.70	5
G254	Repositioning of temporary endocardial electrode	42.90	5
G295	Insertion of permanent endocardial electrode and implantation of pack (includes insertion of temporary transvenous lead at same surgical procedure by same surgeon)	211.10	5
G269	Insertion of permanent endocardial electrode(s)	96.60	
G270	Exposure of vein and implantation of pack	110.90	5
G302	Repositioning of permanent endocardial electrode (as separate procedure)	80.10	5
G264	Replacement of pack	96.60	5
G288	Endomyocardial biopsy — transvascular, right or left	114.50	
G303	Insertion of transthoracic pacemaker	34.30	4
	Electrocardiography: (professional component must include pertinent written interpretation)		
+G310	E.C.G. — technical component	4.65	
G313	— professional component — practice in general	5.00	
G318	— professional component — specialist	6.80	
	Before and after exercise (Master's criteria, Levy Ischemia or Frasher Exercise test) includes complete resting tracing and multiple leads taken immediately and 3 and 6 minutes post exercise.		
G314	— technical component	7.50	
G334	— professional component	7.50	

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Code	CARDIOVASCULAR - Cont'd	Procedural Fee $	Anaes.
	Maximal stress E.C.G. (exhaustion, symptoms, or E.C.G. changes) or sub-maximal stress E.C.G. (to target heart rate for patient) by a standard technique — with treadmill or ergometer and oscilloscopic continuous monitoring including E.C.G.'s taken during the procedure and resting E.C.G.'s before and after the procedure (physician must be in attendance at all times) professional component includes the necessary clinical assessment immediately prior to testing		
G315	— technical component	24.30	
G319	— professional component	36.80	
G316	Vector — technical component	12.50	
G335	— professional component	6.80	
	Continuous ECG monitoring e.g. Holter		
	Level 1 — requires a recorder capable of recording all beats and transmitting this information to a scanner which is capable of analyzing and printing every beat and also performing trend analysis on the 12 or 24 hour tape.		
	Level 2 — requires a recorder capable of recording only a portion of each minute, or a predetermined time period after an abnormal complex is sensed. The scanner of this recorder is capable of analyzing the tape and printing all beats in the predetermined time period analyzing the ST segment, heart rate and ventricular premature beat frequency.		
	Level 3 — requires a recorder capable of recording beats for only a portion of a minute and feeding this information into a scanner through an adapter that feeds the information through the standard E.C.G. machine.		
G650	Level 1 — professional component	32.55	
G651	— technical component — recording	17.70	
G652	— scanning	24.30	
G653	Level 2 — professional component	23.60	
G654	— technical component — recording	17.20	
G655	— scanning	11.80	
G656	Level 3 — professional component	15.70	
G657	— technical component — recording	11.80	
G658	— scanning	7.90	
	Interpretation of telephone transmitted E.C.G. rhythm strip		
G320	— professional component must include pertinent written interpretation	2.90	
G311	— technical component for telephone transmission	1.40	
	Single chamber reprogramming including electrocardiography.		
G283	— professional component	6.40	
G284	— technical component	6.40	
	Dual chamber reprogramming including electrocardiography.		
G180	**— professional component**	**9.65**	
G181	**— technical component**	**8.60**	

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Code	CARDIOVASCULAR - Cont'd	Procedural Fee $	Anaes.
	Pacemaker pulse wave analysis **including** electrocardiography		
G307	— professional component	6.40	
G308	— technical component	6.40	
	Non Invasive Cardiography:		
Note:	When more than one procedure of items marked (*) are peformed at one sitting, the major procedure may be claimed in full and the remainder at 50% of the listed benefit(s).		
	*Phonocardiogram — multiple channel — before and after exercise (not less than 3 channels)		
G504	— professional component	11.80	
G505	— technical component	28.60	
G506	(with pharmacologic intervention), add	5.90	
G507	*Apex cardiogram — professional component	7.15	
G508	— technical component	7.15	
	Echocardiography — see Diagnostic Ultra Sound.		
	Blood Flow Study (Doppler or other) — uni or bilateral		
	*Phlebography and/or carotid pulse tracing (with systolic time intervals) — before and after exercise		
G518	— professional component	7.65	
G519	— technical component	7.65	
G502	Carotid phonoangiography — professional component	7.15	
G503	Oculoplethysmography — professional component	7.15	
	Impedance plethysmography		
G120	— professional component	4.65	
G121	— technical component	9.20	
	Peripheral Arterial and Venous System — see listings under Diagnostic Ultrasound on page 85.		

CRITICAL CARE

Life Threatening Emergency Situation: — Resuscitation in emergency situation (cardiac arrest, massive injury, cardio-respiratory failure, resuscitation of newborn, severe shock, coma) includes immediate crisis related examination and usual resuscitative measures and to include as required, defibrillation, cardioversion, cut down(s), intravenous lines, pressure infusion sets and pharmacological agents, urinary catheters, arterial and/or venous catheters, C.V.P. lines, blood gases, nasogastric tubes with or without lavage, endotracheal intubation and tracheal toilet.

Code		Procedural Fee	Anaes.
G521	Benefit per physician — first ¼ hour	57.20	
G522	— after first ¼ hour (per ¼ hour or major part thereof)	19.00	
	Other Resuscitation:		
G395	Benefit per physician — first ¼ hour	28.60	
G391	— after first ¼ hour (per ¼ hour or major part thereof)	14.30	

Note: Consultations or assessments rendered before or after critical care is no longer necessary, should be claimed on a fee-for-service basis.

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Code		Procedural Fee	Anaes.
	CRITICAL CARE - Cont'd	$	
	Hyperbaric Therapy; (per dive)		
	Physician in chamber with patient(s)		
G800	— per dive, first ¼ hour	38.30	
G801	— after first ¼ hour (per ¼ hour or major part thereof)	19.10	
G802	— after 2 hours in chamber (per ¼ hour or major part thereof)	38.30	
	Physician not in chamber with patient(s)		
	— per dive, charge on the basis of other Resuscitation (G395 and G391)		
	Consultation(s) or assessment(s) and special visit premium(s) may be charged on a per patient basis when these services are rendered.		
Note:	G800, G801, G802 — hyperbaric therapy is not a benefit of OHIP for treatment of some conditions. Please refer to OHIP District Office for qualifying diagnoses.		
G211	Endotracheal intubation for resuscitation (not to be claimed when followed by a surgical procedure)	24.30	
G210	**Hypothermia** (therapeutic) induction and management	130.20	
	Respiratory Care:		
	— includes examinations of the patient and includes (as required), intravenous lines, pressure infusion sets and pharmaceutical agents; insertion of arterial, C.V.P. or urinary catheters; securing and interpretation of blood gases; nasogastric tubes, endotracheal intubation with or without artificial ventilation, tracheal toilet, use of an artificial ventilator and all necessary measures for its supervision.		
	Physician-in-Charge		
G405	— 1st day	128.80	
G406	— 2nd to 5th days (inclusive) per diem	57.95	
G407	— 6th to 28th days (inclusive) per diem	51.50	
G408	— 29th day onwards per diem	32.20	

Notes:

(1) The foregoing benefits apply only to respiratory care rendered in a Respiratory Care Unit or other special care unit such as the ICU where special monitoring equipment is available. The fees under Physician-in-Charge apply per patient treated, i.e., while the Physician-in-Charge may change during the course of treatment, the fee formula as set out should be charged by the physicians involved as if there was only one physician-in-charge during the treatment program.

(2) The appropriate consultation, procedure and visit benefits shall apply after stopping artificial respiration or special care.

(3) If a patient has been discharged from the Respiratory Care Unit more than 48 hours and then is re-admitted to the Unit, the 1st day rate applies again on the day of re-admission. For re-admission less than 48 hours after discharge, the appropriate code G406-G408 should be used.

Code	CRITICAL CARE – Cont'd	Procedural Fee $	Anaes.
	(4) Other physicians apart from those providing respiratory care may claim the appropriate consultation, visit and procedure benefits not listed in the schedule for Respiratory Care. Anaesthetists rendering short duration interim care in the recovery room prior to transfer to the special care unit should submit claims in accordance with the Preamble, Part B, paragraph 36(k). Longer duration care rendered in accordance with the above definition of Respiratory Care should be considered as the applicable first day care G405.		
	Neonatal Intensive Care:		
	Level A: Full life support including invasive monitoring, ventilatory support (all modalities) and parenteral alimentation		
G600	— 1st day	214.65	
G601	— 2nd to 10th days (inclusive), per diem	107.30	
G602	— 11th day onwards, per diem	53.70	
	Level B: Intensive care including full monitoring both invasive and non-invasive. Oxygen administration and intravenous therapy, but without ventilatory support		
G610	— 1st day	139.50	
G611	— 2nd day onwards, per diem	39.35	
	Level C: Intermediate care including oxygen administration, non-invasive monitoring and gavage feeding		
G620	— 1st day	93.00	
G621	— 2nd day onwards, per diem	19.30	

Notes:

(1) The foregoing benefits apply only to care rendered in a Special Care Unit or a Respiratory Care Unit or the ICU where special monitoring equipment is available.

(2) The foregoing benefits include the initial consultation or assessment and subsequent examinations of the patient and, as required, insertion of arterial, venous, C.V.P. or urinary catheters, intravenous lines, interpreting of blood gases, nasogastric tubes, pressure infusion sets, pharmaceutical agents, endotracheal intubation, tracheal toilet, artificial ventilation, and all necessary measures for respiratory support.

(3) These are team benefits which apply to neonatologists/paediatricians/anaesthetists providing complete care. If ventilator care only, is provided by anaesthetist(s), the above listings do not apply. Instead, claims should be rendered under the Respiratory Care listings (G405 etc.) with neonatology paediatric components claimed on a fee-for-service basis.

(4) If an infant has been transferred from one level to another in either direction, up or down, the 2nd day listings apply.

(5) Regular visit and procedure fees will apply the day following termination of Neonatal Intensive Care

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Code	CRITICAL CARE – Cont'd	Procedural Fee $	Anaes.
	(6) If a patient has been discharged from the Neonatal Intensive Care Unit more than 48 hours and then is readmitted to the Unit, the 1st day rate applies again on the day of re-admission. For re-admission less than 48 hours after discharge, the appropriate code G601, G602, G611 or G621 should be used.		
	Intensive Care Monitoring:		
Note:	This category excludes Cardio-Pulmonary Resuscitation and Respiratory Care and should be claimed on the basis of the appropriate consultation, procedure and visit. (Also see Preamble, Part B, paragraph 23(b))		
Code	**DIALYSIS:** team benefits, to include listed items. (This does not include preliminary investigation of the case.)		
	Haemodialysis (to include haemofiltration, haemoperfusion)		
R849	Initial and acute (to include surgical components)	590.30	6
R850	Insertion of Cannula (to be included in the $590.30 initial)	211.10	6
G325	Medical component (to be included in the $590.30 initial)	379.20	
G323	Acute, repeat (maximum of 3)	191.40	
G326	Chronic each	44.40	
	Revision of Cannula		
G327	— single	68.70	4
G328	— both	103.00	4
G329	De-clotting of Cannula	63.10	
R843	Removal of Cannula **or A.V. Shunt**	54.70	4
G324	Insertion of subclavian catheter for haemodialysis	63.10	
G336	— revision	10.40	
R851	By-pass graft for haemodialysis — synthetic	268.30	7
R840	— autogenous vein	286.20	7
R833	Ligation or removal of by-pass graft	55.50	4
R841	Obliteration of A-V fistula	55.45	4
Notes:	— For operative thrombectomy of bypass graft, use code R813, page 168. — For creation of A-V fistula; use code R827, page 169.		
	Peritoneal dialysis:		
G330	Acute (up to 48 hours) includes stylette cannula insertion (temporary)	134.00	
G331	Repeat acute (up to 48 hours) — maximum of 3	122.35	
G332	Chronic (up to 48 hours) — maximum of $126.20 per week	63.10	
R852	Insertion of peritoneal cannula by laparotomy	126.30	6
R853	Insertion of Tenchkov type peritoneal catheter — chronic — by trocar	63.10	4
R854	Removal of Tenchkov type peritoneal catheter	34.30	4

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Code	**DIALYSIS: – Cont'd**	Procedural Fee $	Anaes.
	Home dialysis and self-care dialysis:		
G333	Weekly retainer for administration, routine visits and supervision (plus fee for service for complications)	21.00	
	ENDOCRINOLOGY AND METABOLISM		
+G493	ACTH test — single or multiple, per injection	4.30	
+G337	Antidiuretic hormone response test including the 8 hour water deprivation test	11.40	
+G338	**Clonidine suppression test (for investigation of pheochromocytoma) — with physician present — includes venipunctures**	16.80	
	Glucagon test		
+G494	(Type A) for carbohydrate response	6.90	
+G495	(Type B) for hypertension, pheochromocytoma and insulinoma provocative test (including cold pressor test)	28.60	
G358	Growth hormone exercise stimulation test with physician present (includes venipuncture(s))	16.80	
+G340	Histamine test to include a control cold pressor test	30.60	
+G341	Hypertonic saline infusion test	11.40	
+G342	Implantation of hormone pellets	21.00	
+G497	Insulin hypoglycemia pituitary function test with or without TRH and LHRH alone or in combination	33.60	
+G498	Intravenous glucose tolerance test	6.90	
+G499	Intravenous tolbutamide test	33.60	
+G513	Pentagastrin stimulation for calcitonin	11.40	
+G344	Phentolamine test	28.60	
+G501	TRH and/or LHRH test, per injection	4.30	
+G490	Saralasin test	28.60	
	GASTROENTEROLOGY		
G349	Oesophageal tamponade (Blakemore bag) — insertion	30.60	
	Oesophageal motility study(ies) with manometry		
G350	— standard, with physician in continuous attendance	60.80	
G343	— interpretation only	13.40	
	Oesophageal pH study for reflux		
G251	— standard, with physician in continuous attendance	22.90	
G351	— with 24 hour monitoring	26.80	
G346	— tracing interpretation only	13.40	
	Oesophageal acid perfusion test		
G353	— with physician in continuous attendance	22.90	
G252	— interpretation only	7.30	
	Gastric lavage		
+G355	(a) diagnostic	6.50	
G356	(b) therapeutic — with or without ice water lavage	22.90	

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Code	GASTROENTEROLOGY – Cont'd	Procedural Fee $	Anaes.
+G357	Gastric secretion studies (Augmented Histamine or Histalog, or Pentagastrin) — procedure and supervision	12.60	
G352	Biliary tract provocative test with cholecystokinin	6.50	
	Anal-rectal manometry		
G354	— with physician in continuous attendance	30.60	
G253	— interpretation only	7.30	
	GYNAECOLOGY		
G367	Artificial insemination	17.20	
G363	Cervical mucus penetration test	11.80	
G361	Endometrial flushing	11.80	
+G364	Huhner's test (includes sample taking, examination and interpretation)	11.80	
G366	Hydrotubation — e.g. steroids	21.50	
G368	Insufflation — Rubin's test (included in tubal plastic surgery)	21.50	4
G374	Insufflation and endometrial biopsy (included in tubal plastic surgery)	21.50	4
G378	Insertion of intra-uterine contraceptive device	14.30	
Note:	For removal of I.U.D. see page 205.		
+G365	Papanicolaou smear	3.20	
Note:	**The Papanicolaou smear is included in the fee for** consultation, repeat consultation, general or specific assessment (or re-assessment), **partial assessment**, annual health examination or routine post-natal visit **when a pelvic examination is a normal part of the foregoing services.)**		
U.V.C.	Vaginal insufflation	visit fees	
	INJECTIONS OR INFUSIONS		
+G369	B.C.G. inoculation, following tuberculin tests	3.60	
Note:	Multiple B.C.G. inoculations used for treatment of carcinoma are to be considered experimental and no claims should be made for this service.		
+G370	Bursa, joint, ganglion or tendon sheath, **and/or** aspiration	13.70	
G371	(each additional site or area $6.90, maximum $34.40 per visit)		
Note:	G370, G371 — not allowed in addition to surgical benefits when performed at time of surgery.		
	Chemonucleolysis		
	Lateral discography		
G389	— lumbo sacral disc — as first disc	80.50	4
G390	— any other disc — as first disc	42.10	4
G386	— second and subsequent discs each	21.00	
	Injection for chemonucleolysis		
G392	— initial injection	11.90	

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Code	**INJECTIONS OR INFUSIONS - Cont'd**	Procedural Fee $	Anaes.
G393	— any subsequent injection at other levels, each	6.10	
G396	Injections of extensive keloids	16.80	
G397	— under general anaesthesia	30.60	4
	Intradermal including interpretation, intramuscular or subcutaneous — with visit,		
G372	— each injection	1.50	
	Intradermal including interpretation, intramuscular or subcutaneous — sole reason,		
G373	— first injection — apply basic charge only i.e.	3.60	
Note:	Use for tuberculin or Schick test		
G372	— each additional injection	1.50	
	Intralesional infiltration		
+G375	— one or two lesions	6.10	
+G377	— 3 or more lesions	9.00	
G383	— extensive (see Preamble, part B paragraph 25)	I.C.	
G384	Infiltration of tissues for trigger point	6.10	
G385	— more than one site, add	3.10	
G462	Administration of oral polio vaccine — if only service rendered	1.10	
	Intravenous		
+G376	Infant	6.90	
+G379	Child or adult	4.20	
Notes:	(1) Use these codes for cryoprecipitate infusion. (2) G376, G379 may not be claimed with G279. (3) Except for chemotherapy (G381, G281), injections into established I.V. apparatus may not be claimed.		
+G380	Cut down (including cannulation as necessary)	18.40	
	Chemotherapy (marrow suppressant) **with each injection initialed by a physician** by intravenous infusion for treatment of malignant or auto-immune disease		
+G381	— single injection	9.30	
G281	— each additional injection	4.65	
G382	Supervision of chemotherapy (marrow suppressant) for malignant or auto-immune disease by telephone — monthly	7.70	
	Varicose veins (maximum per visit $13.80)		
+G387	—single injection	6.90	
G388	—multiple (unilateral or bilateral) each additional	3.40	

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Code	INJECTIONS OR INFUSIONS - Cont'd	Procedural Fee $	Anaes.
G510	Management of parenteral alimentation — physician in charge — up to twelve weeks — per visit	12.20	
G511	from thirteenth to twenty-sixth week (not to exceed $36.60 per week) — per visit	12.20	
G512	from twenty-sixth week onwards (not to exceed $73.20 per month) — per visit	12.20	
Note:	G510 — G512 may not be claimed more than once per day and the listed benefit includes the hospital visit necessary to manage the parenteral alimentation (i.e., during the same visit, a hospital visit may not be claimed in addition).		

LABORATORY MEDICINE IN PRIVATE OFFICE

The following fees apply to physicians who perform these particular tests in their own offices. The L.M.S. schedule for Laboratory Medicine on pages L1-L22 for these particular tests **applies to licensed laboratories.**

G001	**Cholestrol total**	**1.30**	
G002	**Glucose, quantitative or semi-quantitative**	**1.10**	
G481	**Hemoglobin screen and/or hematocrit, (any method or instrument)**	**0.90**	
G003	**Lactic dehydrogenase (L.D.H.) total**	**1.30**	
G004	**Occult blood**	**1.10**	
G005	**Pregnancy test**	**2.70**	
G006	**SGOT**	**1.30**	
G007	**Urea nitrogen (B.U.N.)**	**1.10**	
G008	**Uric acid**	**1.10**	
G009	**Urinalysis, routine (includes microscopic examination of centrifuged specimen plus any of S.G., pH, protein, sugar, haemoglobin, ketones, urobilinogen, bilirubin)**	**3.15**	
G010	**— one or more parts of above without microscopy**	**1.35**	
G011	**Fungus culture including KOH preparation and smear**	**9.00**	
G012	**Wet preparation (for fungus, trichomonas, parasites)**	**1.35**	

NEPHROLOGY

G411	Nephrological management of donor procurement — (uni or bilateral) — includes management of the neurologically "dead" donor on life support systems, assessment of renal functions pre-nephrectomy, pre-nephrectomy immunotherapy, assessment as to potential recipients to be called in, etc.	130.20	
G347	Renal perfusion with hypothermia for organ transplantation	65.10	
G348	Renal preservation with continuous machine perfusion	65.10	
G412	Nephrological component of transplantation, including complete patient care for first 48 hours following transplantation	198.90	

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Code	NERVE BLOCKS	Procedural Fee $	Anaes.
Note:	Time units are not applicable to nerve blocks. If one physician gives the anaesthetic and another does the nerve block, claim the anaesthetic under G260, page 88 **Not to be charged when used as local anesthesia for surgical procedures.**		
G213	Auditory ganglion	36.70	
G214	Brachial plexus	36.70	
G215	Coeliac ganglion	56.70	
G239	Differential intrathecal spinal block	85.90	
G216	Epidural spinal block	50.50	
G245	Epidural or intrathecal injection of sclerosing solution	110.90	
G243	Femoral nerve — unilateral	36.70	
G244	— bilateral	55.10	
G224	**— Administered by Operating Surgeon (see Preamble Part B Para 36(o)**	7.15	
	Introduction of epidural catheter for relief of pain:		
G246	— Institution		5
G247	**— Maintenance and/or Supervision (charge hospital visit fees for each additional visit rendered to a maximum of 4 visits per day**	**visit fees**	
E402	**Evenings/Sat/Sun/Hol after 5 p.m./before Midnight — add 30% to G247**		
E403	**After Midnight/before 7 a.m. any night during week add 50% to G247**		
Notes:	**— For obstetrical continuous conduction anaesthesia, see P014, P015 on page 109.** — Also see Preamble, part B, paragraph 36(n).		
G218	Ilioinguinal and iliohypogastric nerves	36.70	
G224	**— Administered by Operating Surgeon (see Preamble Part B Para 36(o))**	7.15	
G219	Infraorbital	23.00	
G220	Intercostal nerve root	23.00	
G221	— for each additional one, add	11.40	
G224	**— Administered by Operating Surgeon (see Preamble Part B Para 36(o))**	7.15	
G222	Intrathecal spinal	50.50	
G225	Mental branch of mandibular nerve	23.00	
G250	Maxillary or mandibular division of trigeminal nerve	50.50	
G241	Obturator nerve — unilateral	36.70	
G242	— bilateral	55.10	
G227	Other cranial nerve block	56.70	
G228	Paravertebral nerve block of cervical thoracic or lumbar or sacral or coccygeal nerves	36.70	
G123	— for each additional one, add (to a maximum total fee of $110.40)	18.40	
G229	Pudendal — unilateral	36.70	
G240	— bilateral	55.10	

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Code	NERVE BLOCKS - Cont'd	Procedural Fee $	Anaes.
G224	**— Administered by Operating Surgeon (see Preamble Part B Para 36(o))**	7.15	
G422	Retrobulbar injection (not to be charged when used as a local anaesthesia)	23.00	
G230	Sciatic nerve	36.70	
G226	— bilateral	55.10	
G224	**— Administered by Operating Surgeon (see Preamble Part B Para 36(o))**	7.15	
	Somatic or peripheral nerves not specifically listed		
G231	— one nerve or site	23.00	
G223	— additional nerve(s) or site(s), add	11.40	
G232	Spleno-palatine ganglion	36.70	
G233	Splanchnic	36.70	
G234	Stellate ganglion	36.70	
G256	Superior laryngeal nerve	23.00	
G235	Supraorbital	23.00	
G236	Sympathetic block(s) (lumbar or thoracic)	36.70	
G237	— bilateral	55.10	
G238	Transverse scapular nerve	36.70	
G217	Trigeminal ganglion	56.70	
E958	When alcohol or other sclerosing solutions are used, add 50% to the appropriate nerve block benefit as listed above with the exception of codes G245 and G246.		
	NEUROLOGY		
G273	Epidural injection of adrenal steroid or autologous blood	49.70	
G274	— post laminectomy into operative site	61.20	
Z804	Lumbar puncture	27.50	
Z805	— with instillation of medication	36.70	
G410	Amytal test (Wada) — bilateral — supervision and coordination of tests	45.90	
G413	Electrocorticogram — supervision and intepretation	114.50	
G419	Tensilon test	13.40	
G551	Katzman test (subarachnoid infusion test) including lumbar punctures	114.50	
	Electroencephalography:		
+G414	Technical component	15.00	
G415	Professional component	15.00	
G416	— with activating or sleep inducing drugs or sleep deprivation, add	10.70	
G417	— inserting subtemporal needle electrodes, add	10.70	

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Code	NEUROLOGY - Cont'd	Procedural Fee $	Anaes.
G544	Polygraphic recording of three parameters in addition to EEG (such as respiration, eye movement, EKG, muscle movements, etc.), add per item (to a maximum of $18.30)	6.10	
G545	Videotape recording of clinical signs in association with spontaneous EEG, add per ¼ hr. (maximum of 1 hour)	9.90	
G546	Radiotelemetry or portable recordings to monitor spontaneous EEG from a freely moving patient, add	20.70	
G547	Simple average evoked potential studies with one sensory modality of stimulation	16.10	
G548	Complex evoked potential studies involving several sensory modalities, multiple threshold determinations, of more than four simultaneous channels of recording, not completely under supervision	42.10	
G549	Complex evoked potential studies performed completely under direct professional supervision	84.40	
G550	Overnight sleep recording — complete interpretation with sleep staging	61.20	
Note:	G550 — if not overnight sleep recording, see code G416.		
G418	Attendance and supervision of E.E.G. during major surgery	107.30	
	OPHTHALMOLOGY		
G424	Contact lens(es) fitting (with follow-up for 3 months)	123.80	
G423	One eye only, when the other eye has been previously fitted by the same physician (**with follow-up for 3 months**)	63.70	
Note:	G424, G423 — Contact Lens fitting is not a benefit except under certain specific conditions. See Preamble, Appendix A.		
G463	Hydrophilic "Bandage" lens fitting	63.70	
G438	Colour vision detailed assessment (not to be charged for screening tests such as Ishihara, HRR and University etc.)	17.20	
G437	Dark adaptation curve (Goldmann adaptometer or equivalent)	24.30	
G453	Electro-oculogram (bilateral) — interpretation benefit	13.95	
+G439	Electro-retinography (bilateral) with report	33.60	
+G425	Fluorescein angiography	33.60	
+G444	Fluorescein angioscopy	9.80	
Note:	G425, G444 — for bilateral procedures, add 50% of the listed benefit.		
G426	Glaucoma provocative tests, including water drinking tests	20.40	
G428	Hess screen examination	6.80	
G427	Ophthalmodynamometry (bilateral)	6.80	
	Radioactive phosphorus examination		
G429	— anterior approach	30.05	
G430	— posterior approach	60.80	
G421	Subconjunctival or sub-Tenons capsule injection	11.30	
Note:	G429, G430, G421 — for bilateral procedures, add 50% of the listed benefit.		
+G435	Tonometry (bilateral)	3.60	

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Code	**OPHTHALMOLOGY - Cont'd**	Procedural Fee $	Anaes.
Note:	Not to be claimed for if done in conjunction with an ophthalmological consultation **or** specific assessment.		
G433	Tonography (bilateral), to include tonometry with or without water	13.95	
G436	Visual fields — Kinetic (with permanent record)	6.80	
G432	Visual fields — Static perimetry	20.40	
G464	Visual evoked response	17.20	
	OTOLARYNGOLOGY		
+G420	Ear syringing or curetting (may not be claimed with Z907) — uni or bilateral	3.40	
	Audiometric Tests		
	Pure tone air with or without bone conduction		
G440	— technical component	6.30	
G525	— professional component	4.10	
	— with speech tests		
G441	— technical component	8.55	
G526	— professional component	5.90	
G442	Impedance audiometry		
	— technical component	5.90	
+G529	— professional component	3.90	
	Advanced testing (may include recruitment, sisi, tone decay, malingering, Bekesy test)		
	— per test		
G443	— technical component (maximum) $14.75	5.90	
G530	— professional component (maximum) $9.75	3.90	
	Hearing aid evaluation, including pure tone air and bone conduction and speech tests		
G447	— technical component	22.30	
+G531	— professional component	7.40	
G445	Hearing aid re-evaluation — technical component	10.05	
+G446	— professional component	3.70	
G527	Fitting of tinnitus masker — technical component	22.30	
+G528	— professional component	7.40	
G811	Cortical evoked audiometry — technical component	22.30	
G812	— professional component	7.15	
	Cortical evoked audiometry, multiple frequency, (minimum of 4 frequencies in each ear) — as required		
N.C.	**by the W.C.B. — technical component**	**N.A.B.**	
N.C.	**— professional component**	**N.A.B.**	
G813	Brainstem evoked audiometry — technical component	22.30	
G814	— professional component	10.70	
	Electrocochleography **(per ear)** — to include myringotomy if performed		
G815	— technical component	22.30	
G816	— professional component	71.55	

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Code	**OTOLARYNGOLOGY - Cont'd**	Procedural Fee $	Anaes.
	Vestibular Function Tests		
+G449	Minimal caloric — professional component only	4.90	
	Fitzgerald-Hallpike method		
G450	— technical component	9.10	
+G532	— professional component	5.90	
	Electronystagmography including caloric and positional testing		
G451	— technical component	22.30	
+G533	— professional component	22.30	
+G452	Electrogustometry — professional component only	9.50	
G454	Stroboscopy — professional component only	11.90	
G191	**Optokinetic tests — professional component only**	5.90	
	PHYSICAL MEDICINE		
	Electromyography and nerve conduction studies		
	Schedule A:		
	Complete Procedure, e.g. conduction studies on two or more nerves and E.M.G. of multiple muscles and/or detailed study of neuromuscular transmission		
G456	— professional component	67.25	
G455	— technical component	8.90	
	Schedule B:		
	Limited Procedure e.g. conduction studies on a single nerve plus limited needle electrode, examination in one area; conduction studies on two nerves without E.M.G.		
G457	— professional component	47.90	
G466	— technical component	7.50	
	Schedule C:		
	Short Procedure, nerve conduction study of a single nerve or repeat E.M.G. of one or two muscles without nerve conduction		
G458	— professional component	29.00	
G468	— technical component	4.65	
Note:	For transcutaneous nerve stimulation, see "electrotherapy" under code G467.		
	Strength duration and chronaxie		
+G460	— major	5.70	
+G461	— minor	3.20	
	Therapeutic Procedures:		
+G465	Manipulation — major joint(s) or spine		
	— one or more joints	9.65	
	(under general anaesthesia, see Surgical Procedures)		

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Code	**PHYSICAL MEDICINE - Cont'd**	Procedural Fee $	Anaes.
+G467	**Miscellaneous therapeutic procedures — as listed below**	5.70	
Note(s)	(1) Not allowed to hospital inpatient, outpatient or approved physiotherapy facility (2) May be claimed by a physician for physiotherapy procedures performed by an appropriately trained paramedical under that physician's direct supervision (see Preamble, Part B, paragraph 19). (3) Only one G467 may be charged per patient visit		
	Intermittent positive pressure breathing treatments (office).		
	Heat — diathermy, heat cabinets, heat cradles or bakers, radiant heat, whirlpool baths, paraffin baths, microtherm, etc.		
	Light — ultraviolet — general, local, orificial, etc.		
	Electrotherapy — Galvanic, Faradic, and sinusoidal currents, iontophoresis, transcutaneous nerve stimulation for relief of pain, etc. (Electrosleep therapy or Sedac therapy are not benefits of O.H.I.P.)		
	Ultra sound		
	Hydrotherapy — contrast baths — hotpacks; local, (arm and leg, whirlpool baths); general (Hubbard) for body immersion or Body Tanks; therapeutic pool, under water exercises, cryotherapy.		
	Mechano Therapy — massage, mechanical device-traction, pulleys and weights, treadles, stationary bicycles, shoulder wheels.		
	Therapeutic Exercise (physiotherapy)		
	P.U.V.A.		
	Location and injection of peripheral motor nerves for reduction of spasticity including electrodiagnosis of motor point:		
G485	Major nerve and/or branches	30.80	
G486	Additional major nerve and/or branches	19.10	
	Repeat procedure within one month		
G487	— major nerve	19.10	
G488	— additional major nerve	12.60	
N.C.	Acupuncture: i.e., including insertion of needle(s) into specifically selected point(s) combined with manual, electrical or thermal stimulation of the needle(s) for the management of pain, performed by a physician	N.A.B.	

PSYCHIATRY

G471	Electroconvulsive therapy (E.C.T.) cerebral-single or multiple	21.50	2
Notes:	— Charges for hospital visits, home or office fees do not apply on a day when E.C.T. or individual psychotherapy is charged, i.e. by same physician, same diagnosis. — Electrosleep therapy or Sedac therapy are not benefits of O.H.I.P.		

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Code	TELERADIOTHERAPY	Procedural Fee $	Anaes.
+G472	Minor teleradiotherapy — X-Ray, 150 K.V.P. or less — charge per treatment visit	7.10	
Note:	For the first minor teleradiotherapy procedure rendered to a patient, the physician may claim the appropriate consultation or assessment in addition to the procedure(s). On subsequent visits, only minor teleradiotherapy plus $3.60 should be claimed unless additional procedures have been performed or unless there has been a complication or change to a totally unrelated diagnosis. In the first exception, minor teleradiotherapy plus the benefit(s) for additional procedures may be claimed. In the second exception, the appropriate assessment and minor teleradiotherapy may be claimed.		
	THERMOGRAPHY (infra-red mammography) — **one or more areas**		
G491	Technical component	11.80	
G492	Professional component	5.90	
	UROLOGY		
G484	Cystometrogram with selective sacral nerve block studies	38.30	
+G475	Cystometrogram and/or voiding pressure studies and/or flow rate with or without postural studies and/or urethral pressure profile including intrepretation with or without use of EMG including interpretation	12.90	
G193	**— Complete multichannel urodynamic assessment pressure/flow studies, urethral pressure monitoring, with or without fluoroscopic cystourethrograph**	17.90	
G194	**— with E.M.G add**	5.70	
+G474	— urethral pressure profile alone including interpretation	5.90	
G477	— interpretation of comprehensive urodynamic studies (when the procedure is done by paramedical personnel)	3.60	
+G476	Prostatic massage	3.60	

OBSTETRICS

1. Obstetrical care is divided into its components. A prenatal **major** assessment **when performed** may be claimed and shall comprise a full history, an inquiry into, and an examination of all parts or systems (and may include a detailed examination of one or more parts or systems), an appropriate record, and advice to the patient. Subsequent prenatal visits shall comprise the necessary history and inquiry, examination, appropriate record, pregnancy related counselling and advice to the patient. Normal (uncomplicated) prenatal care includes a prenatal general assessment visit, then monthly visits to 32 weeks, followed by visits every 2nd week to 36 weeks, then weekly visits until delivery. However, complicated pregnancies may require additional visits. Labour — delivery and postpartum care are listed separately.

2. If an uncomplicated obstetrical patient is transferred from one physician to another physician for obstetrical care, the appropriate assessment fee may be charged by the second physician, followed by prenatal visit fees. **This statement does not apply to physicians substituting for each other or when the second physician sees the patient for the first time in labour.** If the obstetrical patient is referred to a consultant for obstetrical care because of the complexity, obscurity or seriousness of the case, the consultant may claim for a consultation in addition to the prenatal visit benefits.

3. Illnesses resulting from or associated with pregnancy or false labour requiring added home or hospital care should be claimed on a per visit basis.

4. When a pregnant patient visits her physician for a condition unrelated to her pregnancy and apart from her routine scheduled prenatal visits, the physician may charge the appropriate visit benefit.

5. The listings under heading Referred Services may be claimed by the consultant **physician** in addition to the appropriate consultation or visit benefit. They may not be claimed by physicians providing obstetrical care to their own patients.

6. If a consultant is requested by another physician to perform a surgical induction of labour, or emergency removal of a Shirodkar suture (except at delivery) assuming someone else has inserted the suture, the consultant should claim a consultation benefit for this (these) service(s).

7. Medical induction or stimulation of labour may be claimed once per pregnancy by any one physician and only when carried out for a recognized obstetrical complication(s) and does not qualify for detention benefits.

8. The listings for "Attendance at labour and attendance at delivery" and for "Attendance at delivery" may not be claimed by any physician when a patient is transferred to a second physician for normal obstetrical care.

9. Ordinary immediate care of the newborn is included in the labour-delivery benefit and, when the service is rendered by the anaesthetist, it is included in the anaesthetic benefit. Active resuscitation of the newborn provided by any physician may be claimed under codes G521, G522 (Life Threatening Emergency Situation).

10. When a physician provides newborn care and also performs a circumcision on the same newborn or infant, both services may be claimed.

11. When an obstetrician routinely *transfers* all newborns to the care of another physician, the latter should not claim consultation benefits for these "transferrals". If the baby is well, the physician may claim the newborn care in hospital benefit plus code H267 (page 53), attendance at maternal delivery (if this service is given). If the baby is sick, the physician may claim for a general assessment and for attendance at maternal delivery (if this service is given) plus daily visits for as long as his/her services are required. If an obstetrician normally cares for

newborns himself or transfers the care of newborns to a general or family physician but refers a newborn to a paediatrician because of the complexity, obscurity or seriousness of the case, the latter may claim for his service according to the following guidelines:

(a) If attendance at maternal delivery is rendered, code H267 may be claimed and, if a general assessment of the baby is carried out, code C263 may be claimed as well. However a post-natal consultation on the baby (C265) may not be claimed in addition to H267.

(b) If a paediatrician has not attended the delivery, a post-natal consultation may be claimed (if this service is rendered) even though a pre-natal consultation may already have been claimed.

12. When a physician provides prenatal visits, attends labour, assists or administers the anaesthetic at Caesarean Section and visits the patient post-operatively, he is entitled to claim for prenatal visits, attendance at labour assistant's or anaesthetist's benefits for Caesarean Section, and postoperative supportive care while the patient is in hospital.

13. Physicians may claim for assisted breech delivery (P020) when the service includes spontaneous delivery to the umbilicus, with extraction of the shoulders, arms and after coming head.

14. The Preamble applicable to Surgical Procedures also applies to obstetricians, where appropriate.

15. The premiums applicable to Obstetrics are as follows: When **deliveries and other obstetrical procedures done in continuity with the delivery** commence after 5:00 p.m. and before midnight or on Saturday, Sundays and Holidays, increase the procedural fee(s) by 20% (E409). When time of delivery occurs after midnight and before 7:00 a.m. any night during the week, increase the fee for delivery and other obstetrical procedures done in continuity with the delivery by 50% (E410). These premiums are not chargeable in addition to the obstetrical procedural fee(s) if labour is induced by medical and/or surgical means by the same physician. However, a forewater A.R.M. or oxytocin augmentation of labour carried out on a patient in desultory labour does not constitute induction.

Code	**OBSTETRICAL CARE**	Asst.	Obst'n $	Anaes.
	Prenatal Care:			
P003	— General assessment (**major** prenatal visit)		34.30	
P004	— Minor assessment (**all other prenatal visits**)		11.80	
	Labour-Delivery:			
P006	— Vaginal		161.40	
P020	— Operative delivery (i.e. mid-cavity rotation or assisted breech extraction)		178.60	5
P018	— Caesarean section	6	182.00	6
P041	— Caesarean section including tubal interruption ...	6	199.20	6
P042	— Caesarean section including hysterectomy	8	446.50	8
Note:	Attempted vaginal delivery, including episiotomy and repair by same physician not allowed in addition to benefits for Caesarean Section.			

OBSTETRICS

Code	**OBSTETRICAL CARE — Cont'd**	Asst.	Obst'n $	Anaes.
E500	Multiple births, any method of delivery — each child extra		58.40	
Note:	(If one child is born vaginally and the other(s) by Caesarean section, charge P018, P041 or P042 plus one at 85% of P006 or P020, then E500 **for third and subsequent births)**			
P038	Attendance at labour only (when patient is transferred to another centre for delivery)		75.55	
P009	Attendance at labour with physician in attendance at delivery		161.40	
P011	**Attendance at labour with (when same physician assists, or gives anaesthetic at Caesarean Section or gives anaesthetic at operative delivery and charges separately for these services as assistant or anaesthetist)**		109.90	
P010	Attendance at delivery (attending physician or consultant(s)		75.55	
P028	Repair of third degree laceration **i.e. repair of anal sphincter and rectal mucosa**		64.40	4
Z774	Postpartum haemorrhage — exploration of vagina and cervix, uterine curettage		48.10	5
P007	Post natal care in hospital and/or home		37.80	
P008	Post natal care in office		visit fees	
	Referred services (I.O.P.) (when only service(s) rendered)			
P036	Repair of vaginal laceration		42.90	4
P039	Repair of cervical laceration		42.90	4
P029	Removal of retained placenta		42.90	4
P013	Obstetrical anaesthesia			5
	Continuous conduction anaesthesia (see Preamble, Part B, paragraph 36)			
P014	(a) introduction of catheter for analgesia including first dose			5
P015	(b) maintenance and/or supervision **(charge hospital visits fee for each visit rendered to a max. of 4 visits)**			
E402A	Evenings/Sat/Sun/Hol. after 5 P.M./before Midnight add 30% to P015A			
E403A	After Midnight/before 7 A.M. add 50% to P015A			
E100C	(a) attendance during delivery — per ¼ hour, claim time units			
G224	Pudendal block (bilateral) see Preamble part B para. 36(o)		7.15	

OBSTETRICS

Code	**OBSTETRICAL CARE —Cont'd**	Asst.	Obst'n **$**	Anaes.
	High risk pregnancies			
Z776	Fetal blood sampling (I.O.P.)		24.00	
Z773	Fetoscopy (may include fetal blood sample, cell harvest or amniocentesis) (I.O.P.)		116.80	
Z739	Oxytocin challenge test (I.O.P.)		34.30	
P037	Double set up to rule out placenta praevia if patient does not proceed to Caesarean section		41.20	
P022	Oxytocin infusion for induction of labour (see **Obstetrics Preamble** paragraphs 7 and 15)		48.10	
P023	Oxytocin infusion for stimulation of desultory labour — see **Obstetrics Preamble** paragraphs 7 and 15		48.10	
Z721	**Pharmacological suppression of premature labour by i.v. therapy — chargeable once per pregnancy by most responsible physician after 3 hours of supervision in same institution (I.O.P.)**		17.90	
Z778	Amniocentesis (I.O.P.) **diagnostic or genetic**		30.90	
P031	Suture incompetent cervix during pregnancy (I.O.P.) (Shirodkar procedure)	3	107.30	4
U.V.C.	Elective removal of Shirodkar suture		**visit fee**	
P034	Uterine inversion, manual replacements		89.30	4
Note:	Listings for ectopic pregnancy, hysterotomy, abortion and post partum tubal interruption are listed under Female Genital System.			

SURGICAL PROCEDURES

Preamble:

FOR DEFINITION OF THE ROLE OF THE REFERRING PHYSICIAN, SEE REFERRING PHYSICIAN SERVICES ON PAGE

FOR DEFINITION OF THE ROLES OF THE ANAESTHETIST, SEE ANAESTHETIST SERVICES ON PAGE

(1) The surgical benefit (except for fractures or disclocations requiring no reduction and other procedures either marked "I.O.P." or including complete care) includes hospital visits rendered by the surgeon two days prior to surgery, the operative procedure, the post-operative care usually associated with the procedure(s) rendered by the surgeon while the patient is in hospital, and one office visit for follow-up examination, if necessary. If the surgeon is required to provide listed services not usually associated with the procedure(s), he may claim for these. If special visits to hospital are required and rendered, the surgeon may claim the appropriate special visit premium even if the basic hospital visits are not chargeable.

The surgical benefit as noted above does not include the major pre-operative visit (e.g. consultation, general assessment, etc.) at which the decision to operate is made, regardless of the time interval between the major pre-operative visit and the surgery. The hospital or day-surgery admission assessment (consultation, repeat consultation, general assessment or re-assessment, specific assessment or re-assessment) may not be claimed by the surgeon unless it happens also to be the major pre-operative visit as defined above. Visits rendered prior to admission (excluding admission assessments) and hospital visits (minor assessments) rendered prior to two days before the surgery may be claimed in addition to the surgical benefit. For patients remaining in hospital because of complications, visit benefits may be claimed in addition to the surgical benefit after **eight weeks of hospitalization in the case of fractures and dislocations and after** the second post-operative week **for other procedures**. The starting point for calculating the appropriate number of hospital visits allowed in accordance with the Schedule after the second **or eighth** post-operative week is the date of admission if the operating surgeon has admitted the patient or the date of referral if the patient has been referred to the operating surgeon while in hospital.

The listed surgical benefit includes the generally accepted surgical components of the procedure. The listed benefit of a procedure normally also includes any necessary repair of iatrogenic damage occurring during the course of the surgery.

(2) When a physician makes a special trip to perform a non-elective surgical procedure during the daytime (Monday to Friday), he may claim the appropriate special visit, a consultation if the case is referred (except for fractures or dislocations requiring no reduction) or the appropriate assessment if the case is not referred plus the procedural benefit(s). When the special visit is to deal with fractures or dislocations requiring no reduction, a minor **or partial** assessment is the appropriate benefit to be added to the special visit and fracture or dislocation benefits. If the non-elective procedure is carried out at night (after 5:00 p.m. and before 7:00 a.m.), or Saturdays, Sundays and Holidays, the physician may claim a special visit applicable to the consultation or assessment and the surgical premium **E409** or **E410** (see Preamble, Part B, paragraph 23).

(3) When more than one operative procedure (non-I.O.P.) is performed by the same surgeon at the same time and/or under the same anaesthetic or **within 14 days** during the same hospitalization for the same condition, the benefit shall be the full benefit for the major

procedure plus 85% of the listed benefit(s) for additional procedures, unless otherwise indicated in the Schedule and except where such combined operations are independently specified as items in this Schedule. This paragraph applies to staged procedures and to each side of bilateral procedures, but does not apply in the case where a normal appendix or simple ovarian or para-ovarian cyst is removed incidentally during an operation, for which no claim should be made (see also OHIP Bulletin #4122, July 3, 1979).

(4) When a subsequent operation(s) becomes necessary for the same condition because of a complication, the full benefit will apply for each procedure.

(5) When a subsequent non-elective operation(s) is performed for a new condition, the full benefit will apply for each procedure.

When a subsequent elective procedure is done for a different condition **within 14 days** during the same hospitalization **by the same surgeon**, the benefit for the lesser procedure shall be reduced by 15% unless performed by another surgeon in which case the full benefit will apply.

(6) When different operative procedures are done by two different surgeons under the same anaesthesia for different conditions, the benefit will be 100% of the listed benefit for each condition. Under these circumstances, the basic assistants' units should not be claimed by either operating surgeon; however time units may be claimed when appropriate.

(7) As a general rule, when elective bilateral procedures are performed by two surgeons at the same time, one surgeon should claim for the surgical procedures and the other surgeon should claim the assistant's benefit.

(8) Where two surgeons are working together in surgery in which neither a team benefit nor other method of claiming is set out in the schedule, the surgeon should identify himself as the operating surgeon and claim accordingly; the surgeon who is assisting him should identify himself as such and claim the assistant's benefit. Where the second or assistant surgeon is brought into the case on a consultation basis, he may, when indicated, claim a consultation as well but should be prepared to justify it on an I.C. basis. If the nature or complexity of a procedure requires more than one operating surgeon each providing a separate service in his own specialized field, each surgeon may claim the full listed benefit for the procedure he performs. This, however, does not apply to those cases wherein an additional surgeon(s) is involved simply because he may be more skillful at carrying out a procedure which the first surgeon normally should be able to do. Neither does it apply to those cases wherein one or more additional surgeons perform components of a main procedure for which there is a listed combined tariff. For the latter two circumstances, the first portion of this paragraph pertains and the additional surgeon(s) may claim assistant's benefits only, along with consultation and visits if appropriate. If a surgeon, in addition to performing a specialized portion of the procedure, acts as an assistant during the remainder of the procedure, he may also claim time units (but not basic units) for assisting.

(9) Unless otherwise stated, the listed procedural benefits are for unilateral procedures.

(10) When a procedure is performed, a procedural benefit, if listed, should be claimed. Substitution of consultation and/or visit benefits for procedural benefits (except as in paragraph 11), is not in keeping with the intent of the schedule.

(11) For fractures and dislocations requiring no reduction and for other procedures which include complete care, when the listed benefit is less than the consultation benefit and the case is referred, the physician may claim for the consultation instead of the surgical benefit.

However, to avoid the consultation being counted as such under the OHIP limitation rules on the number of consultations allowed per year, the physician should claim for the consultation under the surgical procedure nomenclature or code. Since the consultation is replacing a procedural benefit which includes the pre- and post-operative and surgical care, no additional claims beyond the consultation should be made.

(12) If a physician performs a minor surgical procedure and during the same visit assesses and treats the patient for another completely unrelated and significant problem involving another body system, the physician may claim for the procedure as well as for the appropriate assessment.

(13) Where a procedure is specified as "Independent Operative Procedure (I.O.P.)", the procedural benefit may be claimed in full. In addition, visit benefits, consultations etc. may be claimed when both services are actually rendered. When an I.O.P. procedure is done in conjunction with non-I.O.P. procedure(s), no claim may be made for the consultation, pre- and post-operative care related to the I.O.P. procedure. The listed I.O.P. benefit may be claimed in these circumstances along with the benefits for the non-I.O.P. procedure(s) and the related major pre-operative visit in accordance with paragraph (1) of this Preamble. When multiple or bilateral I.O.P. procedures are performed at the same time by the same physician, the listed procedural benefits may be claimed in full but the pre- and post-operative benefits should be claimed as if only one procedure had been performed. **When a patient is examined in a physician's office and this leads to an elective Independent Operative Procedure (I.O.P.) being performed for the same problem or diagnosis by the same physician in the Emergency or Outpatient Department on a non-admission basis, the physician should claim a consultation or visit fee for the examination in the office and the fee for the I.O.P. carried out in the Emergency or Outpatient Department. An additional assessment fee at the time of the elective I.O.P. should only be claimed when an additional assessment is performed.**

(14) When procedures are specifically listed under Surgical Procedures, physicians should use these listings rather than applying one of the plastic surgery benefits listed under operations on skin and subcutaneous tissue.

(15) For excision of tumours not specifically listed in this Schedule, claims should be made on an I.C. basis (code **R993**). Independent consideration also will be given (under code **R990**) to claims for other unusual but generally accepted surgical procedures which are not listed specifically in the Schedule (excluding non-major variations of listed procedures). In submitting claims, physicians should relate the service rendered to comparable listed procedures in terms of time and difficulty (see Preamble, Part B, paragraph 25).

Independent consideration also will be given (under code **R991**) to out-of-Province claims for generally accepted surgical procedures which are not available in Ontario, for which a patient has been referred by an Ontario physician and for which prior approval from OHIP has been obtained. (See OHIP Bulletin #4148)

(16) Cosmetic or Aesthetic Surgery: means a service to enhance appearance without being medically necessary such as surgery for correction of facial wrinkles, surgery for eyelid wrinkles (symmetrical and without a functional problem), rhinoplasty for appearances only, etc. These services are not benefits of OHIP. (See Preamble, Appendix A).

(17) Reconstructive Surgery: is surgery to improve normal appearance and/or function to any area altered by disease, trauma or congenital deformity. Although surgery solely to restore appearance may be included in this definition under certain limited conditions, emotional,

psychological or psychiatric grounds normally are not considered sufficient additional reason for OHIP coverage of such surgery.

Appendix D of the Preamble to this Schedule describes the conditions under which surgery for alteration of appearance, only, may be a benefit of the Plan.

Physicians should submit requests to their District OHIP office for authorization of any proposed surgery which may fall outside of OHIP coverage. Among those procedures for which requests *must* be submitted before the procedure is performed are:

(a) augmentation mammoplasty (excluding post-mastectomy breast reconstruction)
(b) blepharoplasty
(c) dermabrasion (excluding face and neck)
(d) epilation of hair
(e) face lift
(f) hair transplant
(g) panniculectomy, lipectomy
(h) reduction mammoplasty
(i) rhinoplasty or septorhinoplasty
(j) scar revision (excluding face and neck)
(k) sex-reassignment surgery
(l) tattoo removal (excluding face and neck)

Requests for authorization of proposed surgery should identify the medical necessity of the surgery. Moreover, since it is the procedure for which the authorization request is being made, it must be adequately described and accurately related to the condition it is intended to alleviate.

Note that when a surgical procedure is not a benefit of the Plan, the associated anaesthetist's charges, assistant's charges and hospital costs normally also are excluded from OHIP coverage.

(18) Procedural benefits (non I.O.P.) include the removal of sutures where both services are rendered by the same physician unless the removal of sutures is done after one office visit for follow up examination has already been provided. If sutures are removed subsequent to the first post-operative office visit, or if they are removed by a physician other than the operating surgeon, or following an I.O.P. procedure, "visit fees" apply.

(19) Additional claims for biopsies performed when a surgeon is operating in the abdominal or thoracic cavity may be given independent consideration.

(20) When a procedure is performed for which only "local anaesthetic" and/or "general anaesthetic" listings appear, and an anaesthetic is not required, the procedure should be claimed under the "local anaesthetic" listing. When a physician administers an anaesthetic and/or other medication prior to or during a procedure(s) and also performs a procedure(s) on the same patient, he should claim for the procedure(s) only.

(21) If claims are being submitted in coded form, the surgeon should add the suffix A to the listed procedural code, the surgical assistant should add the suffix B to the listed procedural code and the anaesthetist should add the suffix C to the listed procedural code.

SURGICAL PROCEDURES

OPERATIONS ON THE INTEGUMENTARY SYSTEM

Code	SKIN AND SUBCUTANEOUS TISSUE	Asst.	Surg.	Anaes.
	Incision (I.O.P.)		$	
	Abscess(es) or Haematoma(s)			
	local anaesthetic — subcutaneous			
Z101	— one		13.60	
Z173	— two		20.60	
Z174	— three or more		27.50	
Z104	— perianal		13.60	
Z106	— ischiorectal or pilonidal		30.05	
Z103	— palmar or plantar spaces		30.05	
	general anaesthetic — subcutaneous			
Z102	— one		30.05	4
Z172	— two or more		45.10	4
Z105	— perianal		30.05	4
Z107	— ischiorectal or pilonidal		48.80	4
Z108	— palmar or plantar spaces		48.80	4
	Comedones, acne pustules, milia			
Z119	— ten or less		2.60	
Z120	— eleven or more		9.30	
Z114	Foreign body removal — local anaesthetic		12.80	
Z115	— general anaesthetic	3	60.10	4
Z100	— complicated (see Preamble, Part B, paragraph 25)	4	I.C.	4
Z227	Intra muscular abscess or haematoma		68.70	4
Z116	Biopsy(s) — any method — when sole procedure		10.00	
Z155	— extensive, complicated or requiring general anaesthetic — when sole procedure (see Preamble, part B, paragraph 25)		I.C.	I.C.
Z245	Biopsy for malignant hyperthermia, three or more		103.00	8
	Excision (with or without biopsy)			
	Lesions — single or multiple sites, uni- or bilateral (I.O.P.).			
	Group 1 — verruca, papilloma, keratosis, pyogenic granuloma, spider naevus			
UVC	Paring of warts or corns without complete removal		visit fees	
	Removal by excision and suture			
Z156	— single lesion		10.00	4
Z157	— two lesions		15.00	4
Z158	— three or more lesions		25.00	4

SURGICAL PROCEDURES

OPERATIONS ON THE INTEGUMENTARY SYSTEM

Code	SKIN AND SUBCUTANEOUS TISSUE - Cont'd	Asst.	Surg. $	Anaes.
	Removal by electrocoagulation and/or curetting			
Z159	— single lesion		7.15	4
Z160	— two lesions		10.70	4
Z161	— three or more lesions		17.90	4
	Group 2 — naevus			
	Removal by excision and suture			
Z162	— single lesion		10.00	4
Z163	— two lesions		15.00	4
Z164	— three or more lesions		25.00	4
Z165	— congenital (extensive) (see Preamble, Part B, paragraph 25)		I.C.	I.C.
Note:	Removal of naevi for cosmetic purposes and not for functional impairment or for clinical suspicion of disease or malignancy is not a benefit of OHIP (see Preamble, Appendix D) and may be billed to the patient.			
	Group 3 — plantar verruca			
U.V.C.	Paring of warts and corns without complete removal		visit fees	
	Removal by excision and suture			
Z166	— single lesion		19.70	4
Z167	— two lesions		29.30	4
Z168	— three or more lesions		48.80	4
	Removal by electrocoagulation and/or curetting			
Z169	— single lesion		13.60	4
Z170	— two lesions		20.60	4
Z171	— three or more lesions		40.60	4
	Group 4 — cyst, haemangioma, lipoma			
	Face or neck			
Z122	local anaesthetic — single lesion		21.80	
Z123	— two lesions		32.20	
Z124	— three or more lesions		44.40	
Z145	general anaesthetic — single lesion	3	45.10	4
Z146	— two lesions	3	63.70	4
Z147	— three or more lesions	3	90.15	4
Z148	— extensive or massive (see Preamble, Part B, paragraph 25)	3	I.C.	5
	Other areas			
Z125	local anaesthetic — single lesion		16.80	
Z126	— two lesions		25.90	
Z127	— three or more lesions		33.80	
Z149	general anaesthetic — single lesion	3	33.80	4
Z150	— two lesions	3	45.10	4
Z151	— three or more lesions	3	63.70	4
Z152	— extensive or massive (see Preamble, Part B, paragraph 25)	3	I.C.	5
R034	Congenital dermoid cyst	3	82.30	4

SURGICAL PROCEDURES

OPERATIONS ON THE INTEGUMENTARY SYSTEM

Code	SKIN AND SUBCUTANEOUS TISSUE – Cont'd	Asst.	Surg. $	Anaes.
R037	Giant cell tumour	3	82.30	4
	Pilonidal cyst			
R035	— simple excision or marsupialization	3	123.80	4
R036	— excision and skin shift	3	164.60	4
	Inguinal, perineal or axillary skin and sweat glands for hyperhydrosis and/or hidradenitis			
R059	— unilateral	3	175.30	5
R060	— with skin graft(s) or rotation flap(s)	3	264.70	6
	Malignant Lesions including biopsy of each lesion — single or multiple sites Simple excision			
R094	localized malignancy — single lesion	3	39.35	4
R040	— two lesions	3	64.40	4
R041	— three or more lesions	3	128.80	4
E544	— add 25% if lesion on face or neck.			
	Curettage and electrodessication or cryosurgery			
R031	localized malignancy — single lesion	3	37.60	4
R032	— two lesions	3	61.90	4
R033	— three or more lesions	3	123.80	4
E544	**— add 25% if lesion on face or neck.**			
R081	Chemosurgery (Mohs technique) (see Preamble, Part B, paragraph 25)		I.C.	I.C.
Note:	**When excision of benign, malignant or premalignant lesions are corrected by advancement, rotation, transposition, "Z" plasty, flap or graft, charge appropriate fee listed under Repair section instead of foregoing excision fees.**			
	Repair Debridement and Dressing (I.O.P.) not chargeable in addition to any surgical procedure unless complication(s) require such care in excess of the usual post-operative care)			
U.V.C.	— minor		visit fees	
Z153	— major **not to be claimed in addition to Z176**		9.30	
Z144	— requiring general anaesthetic	4	38.30	4
R082	— extensive (see Preamble, Part B, paragraph 25)	4	I.C.	5
	Burns I.O.P.			
Z180	**Resuscitation — major burn, initial care, 1st 24 hours**		71.55	
Z181	**— continuing care (up to 3 days) per day**		35.80	
R637	**Debridement and excision**		10.70	
R638	**Excision and graft of burn**		21.50	

SURGICAL PROCEDURES

OPERATIONS ON THE INTEGUMENTARY SYSTEM

Code		Asst.	Surg.	Anaes.
	SKIN AND SUBCUTANEOUS TISSUE - Cont'd **Suture (I.O.P.)** Simple and uncomplicated		$	
Z176	— insertion of sutures only		10.00	
U.V.C.	— removal of sutures only (See Surgical Preamble, paragraph (18)		visit fees	
Z178	— extensive, multiple, complicated, primary or secondary (including post-operative haemorrhage) or requiring general anaesthetic — **see following guidelines**		I.C.	4
E542	— when sutures are inserted in private office, add		3.80	

Notes: (1) The benefits for Z176, Z178 include the use of sutures, local anaesthetic, tetanus toxoid and routine observation until the sutures have been removed.

(2) With the accord of the Ontario Medical Association, the following guidelines are suggested to assist in the determination of an appropriate charge to submit for independent consideration under Code Z178 for suture of skin lacerations:

(i) The suturing of most simple lacerations smaller than approximately 4 cm in length should be coded as Z176 (plus E542 if applicable) and claimed accordingly.

(ii) The suturing of other lacerations should be claimed under code Z178 (**plus E542 if applicable**) on an Independent Consideration basis according to the following guidelines:

(a) The stated benefits are for suturing the laceration only; the appropriate consultation or visits may be claimed in addition.

(b) Simple lacerations with a length **of** 4 cm **or more,** but less than approximately 8 cm $24.50

(c) Lacerations in difficult area (e.g. lip, eyelid, eyebrow, corner of eye, etc.) or which are deep such that they require tying off bleeders and/or closure in layers (i.e. subcutaneous and cutaneous) $24.50

(d) Lacerations involving components of both (b) and (c) $49.00

(e) Lacerations requiring extensive debridement, add 50%.

(f) A combination of 2 or 3 lacerations falling within the foregoing guidelines would require individual assessment of each laceration. e.g.: for the suturing of a 6.5 cm scalp laceration requiring tying off bleeders and/or layer closure, a 2.5 cm cheek laceration and 1 cm laceration through the mucocutaneous border of the lip, the benefit claimed could be calculated as follows:

Scalp (d)	$49.00
Cheek (Z176)	10.00
Lip (c)	24.50
Total (Z178)	$83.50

(plus the appropriate consultation and visit benefits)

(g) More complicated lacerations should be compared in scope and difficulty with other similar services which have definitive benefits listed in the Schedule.

3. In every case, claims for Z178 should be accompanied by sufficient description of the procedure rendered and an explanation of the charges submitted *(see Preamble, Part B, paragraph 25)*.

SURGICAL PROCEDURES

OPERATIONS ON THE INTEGUMENTARY SYSTEM

Code		Asst.	Surg. $	Anaes.
	Muscle Repair			
R525	— simple muscle repair(s) to include repair of involved skin	3	61.20	4
R528	— complex muscle repair (see Preamble, Part B, paragraph 25)	4	I.C.	6

Skin Flaps and Grafts

Notes:
(1) The benefit will depend on the size and location of the area grafted and the type of graft.
(2) Additional procedures other than the skin grafting are extra, e.g. tendon grafts, inlay grafts, etc.
(3) Skin grafts or pedicle flaps done during a procedure should be claimed for on their own merit (unless specifically listed as being inclusive for that procedure).

Code		Asst.	Surg. $	Anaes.
	Skin Flaps			
	A. Advancement flaps (to include undermining of more than 2.5 cm per side) — is intended to include excision of lesion or scar if this technique of closure			
R002	with **defect** of **2.1-5 cm.**	3	40.40	4
R003	with **defect** of **5.1-10 cm.**	3	61.20	5
R004	**If beyond** 10 cm. e.g. thoracic abdominal flap (see Preamble, Part B, paragraph 25)	4	I.C.	6
E543	— add 50% if defect on face or neck			
	B. Rotations, Transpositions, "Z" plasty(ies) (includes undermining) but will depend on the site and size			
R072	Defect less than 2 cm. average diameter	3	91.90	4
R075	Defect **2.1** cm. to 5 cm. average diameter	3	153.80	4
R073	Defect **5.1** cm. to 10 cm. average diameter	4	218.20	4
R074	Defect more than 10 cm. average diameter (see Preamble, Part B, paragraph 25)	4	I.C.	5
E545	— add 50% if defect on face or neck			
	C. Pedicle Flaps — direct			
R079	Small e.g. cross finger	4	91.90	4
R077	— each subsequent stage	4	69.00	4
R070	Intermediate e.g. cervical finger	4	202.80	5
R071	— each subsequent stage	4	153.80	5
R080	Large e.g. cross leg	4	286.20	6
R078	— each subsequent stage	4	214.65	6

SURGICAL PROCEDURES

OPERATIONS ON THE INTEGUMENTARY SYSTEM

Code		Asst.	Surg. $	Anaes.
	D. Pedicle Flaps — indirect			
R103	Delay of tube or pedicle		44.00	4
R101	Minor stage — per operation	3	91.90	4
R100	Major stage — per operation	4	202.80	5
	E. Myo-Cutaneous Flaps (to include closure by any method)			
R005	Sterno-mastoid, pectoralis major, latissimus dorsi	4	344.50	6
R006	Tensor fascia lata, gluteus maximus, gracilis, sartorius, rectus femoris, gastrocnemius (medial and lateral), rectus abdominis	3	262.20	5
R008	**Extended Rectus Abdominis**	6	459.35	8
R009	**Myocutaneous — osseous flaps e.g. pectoralis major myocutaneous flap with rib graft, trapezius flap with scapular spine**	6	536.60	8
R007	Other (see Preamble, Part B, paragraph 25)	I.C.	I.C.	I.C.
	Skin Grafts (Includes taking the skin for grafting)			
	A. Split Thickness Grafts			
R084	Very minor, very small areas, e.g. trauma		65.10	4
R085	Minor, medium sized areas, e.g. small or average skin ulcer, breast, etc.	3	99.45	4
R086	Intermediate or large areas, e.g. trunk, arms, legs, etc.	4	183.90	4
R087	Major or complex areas, e.g. face, neck, hands, etc.	4	275.50	5
R088	Extensive major, very large areas	4	402.10	6
	B. Full Thickness Grafts			
R092	Minor — less than 1 cm. average diameter		65.10	4
R093	Intermediate — 1 to 5 cm. average diameter	3	99.45	4
R083	Major — over 5 cm. (see Preamble, Part B, paragraph 25)	5	I.C.	5
R091	Complex — eyelid, nose, lip face	4	149.20	5
Note:	Descriptive details of procedure (e.g.: operative report) should be submitted with claims for code R091.			
R057	Appendage or tissue re-vascularization involving microanastomosis with or without microneuroanastomosis	I.C.	I.C.	I.C.
R058	— revision of above (see Preamble, Part B, paragraph 25) Digital re-implantation — see R602-R605, page 131.	I.C.	I.C.	I.C.

SURGICAL PROCEDURES

OPERATIONS ON THE INTEGUMENTARY SYSTEM

Code		Asst.	Surg. $	Anaes.
	Neurovascular Island Transfer			
R061	Minor e.g. finger tip	3	99.45	4
R062	Intermediate e.g. finger to thumb **transfer**	4	183.90	5
R063	Major e.g. foot to heel	4	306.20	6
	Free Island Flaps			
R064	Elevation of free island skin and subcutaneous flap and closure of defect	10	608.20	10
R065	Preparation of microvascular recipient site for free island skin subcutaneous flap		608.20	
R066	Transplantation of free island skin and subcutaneous flap with microvascular anastomosis		608.20	
R067	Elevation of innervated free island skin and subcutaneous flap and closure of defect	10	669.00	10
R068	Preparation of microvascular recipient site for innervated free island skin and subcutaneous flap		669.00	
R069	Transplantation of innervated free island skin and subcutaneous flap with microvascular anastomosis and nerve repair		669.00	
R125	Elevation of free island skin and muscle flap and closure of defect	10	608.20	10
R126	Preparation of microvascular recipient site for free island skin and muscle flap		608.20	
R127	Transplantation of free island skin and muscle flap with microvascular anastomosis		608.20	
R128	Elevation of free island muscle flap with tendon and nerve, and closure of defect	10	822.80	10
R129	Preparation of microvascular recipient site for muscle, tendon and nerve anastomosis		822.80	
R130	Transplantation of free island muscle flap with tendon, nerve and microvascular anastomosis		822.80	
R131	Elevation of free island bone flaps and closure of defect	10	608.20	10
R132	Preparation of microvascular recipient site for free island bone flap		608.20	
R133	Transplantation of free island bone flap with microvascular anastomosis and bone fixation		669.00	
R134	Elevation of free island skin and bone flap and closure of defect	10	729.80	10
R135	Preparation of microvascular recipient site for free island skin and bone flap		729.80	
R136	Transplantation of free island skin and bone flap with microvascular anastomosis and bone fixation		729.80	
R137	Elevation of free toe or finger and closure of defect	10	729.80	10
R138	Preparation of microvascular recipient site for free toe or finger transplant		729.80	
R139	Transplantation of free island toe or finger with microvascular anastomosis and tendon nerve and bone repair		729.80	
R025	Revision of free island flaps (see Preamble, Part B, paragraph 25)	10	I.C.	10

SURGICAL PROCEDURES

OPERATIONS ON THE INTEGUMENTARY SYSTEM

Code		Asst.	Surg. $	Anaes.
R106	Skin flaps and grafts — other than listed above (see Preamble, Part B, paragraph 25)	I.C.	I.C.	I.C.
	Destruction			
	Epilation of facial hairs (I.O.P.)			
Z121	— per quarter hour		11.80	
Note:	Claims for the above procedure require O.H.I.P. authorization (see Surgical Preamble, paragraph (17)).			
	Finger or toe-nail (I.O.P.)			
Z128	Simple partial or complete — one		16.10	4
Z129	— multiple		24.00	4
	Radical, including destruction of nail bed			
Z130	— one		40.60	4
Z131	— multiple		56.30	4
	Chemical **and/or cryotherapy** treatment of minor skin lesions (I.O.P.)			
Z117	— one **or more** lesions **per treatment**		7.50	
	Plastic planing, Dermabrasion			
	— face for acne			
R096	— each area		69.00	4
R104	— both cheeks		145.20	4
R097	— whole face		221.80	4
R098	— single area e.g., trauma scar		40.10	4
Notes:	(1) R096, R104, R097 — not a benefit of OHIP for areas other than the face. (2) R098 — Claims for this procedure require O.H.I.P. authorization (see Surgical Preamble, paragraph (17)).			
R099	Rhinophyma, removal by shaving		178.90	4
R089	**Webbed Fingers** — one web space	4	191.40	5
R090	**Webbed Toes** — one web space	4	88.00	4
Note:	benefit includes skin flaps or grafts if necessary.			
	Scar Revision			
R026	Up to 2.5 cm.	3	40.10	4
R027	2.6 to 5 cm.	3	61.20	4
R028	5.1 to 10 cm.	3	122.35	5
R029	Over 10 cm. (see Preamble, Part B, paragraph 25)	4	I.C.	6
E541	— add 50% if revision on face or neck.			
Note:	OHIP authorization is required for all scar revision in areas other than the face or neck (see Preamble, Appendix D)			
	Plastic Surgery Procedures: (see Surgical Preamble, paragraphs (14), (17)).			
R150	Very Minor		65.10	4
R151	Minor	3	99.45	4

SURGICAL PROCEDURES

OPERATIONS ON THE INTEGUMENTARY SYSTEM

Code		Asst.	Surg. $	Anaes.
R152	Intermediate	4	183.90	4
R153	Major	4	275.50	5
R154	Extensive Major	4	402.10	6
Notes:	(1) Descriptive details of procedure (e.g.: operative report) should be submitted with claims for codes R150-R154. (2) Taking of skin by a surgeon for grafting by an Oral Surgeon claim as R150.			

OPERATIONS ON THE BREAST

Code		Asst.	Surg.	Anaes.
	Incision			
Z141	Needle biopsy — one or more (I.O.P.)		16.45	
Z139	Aspiration of cyst — one or more (I.O.P.)		16.45	
	Drainage of intramammary abscess or haematoma — single or multi loculated (I.O.P.)			
Z140	— local anaesthetic		16.45	
Z740	— general anaesthetic		41.30	4
	Excision			
R107	Tumour or tissue for diagnostic biopsy and/or treatment e.g. carcinoma, fibroadenoma or fibrocystic disease (single or multiple — same breast)	3	90.15	4
R111	Partial mastectomy or wedge resection for treatment of breast disease e.g. carcinoma or extensive fibrocystic disease	3	135.20	4
E546	**— with radical axillary node dissection, add**		157.40	
R115	Mastectomy — male (benign) — unilateral — simple	3	116.40	4
R116	— subcutaneous with nipple preservation	4	180.30	5
R108	Mastectomy — female (with or without biopsy) — simple	4	180.30	5
R117	— subcutaneous with nipple preservation	4	180.30	5
R109	Mastectomy, radical or modified radical (with or without biopsy)	5	330.60	6
Z142	Removal of breast prosthesis (I.O.P.)	3	52.60	4
Z133	Breast capsulotomy closed (I.O.P.) — no anaesthetic		8.40	
Z134	— general anaesthetic	3	52.60	4
Z135	open **capsulotomy** with or without replacement of breast prosthesis **I.O.P**	3	131.65	4

OPERATIONS ON THE INTEGUMENTARY SYSTEM

Code	OPERATIONS ON THE BREAST - Cont'd	Asst.	Surg. $	Anaes.
	Repair			
	Post-mastectomy breast reconstruction			
R118	— breast skin reconstruction by **local** flaps or grafts .	4	275.50	5
R119	— breast mound creation by prosthesis and/or soft tissue	4	207.50	5
Notes:	(1) R119 should not be claimed for immediate post-mastectomy prosthesis insertion. Use R112 instead. (2) For reconstruction with myocutaneous flaps, see pages 119, 120.			
R114	— secondary revision of breast mound	3	157.40	4
R120	— nipple reconstruction by grafts	3	157.40	4
R113	Nipple harvesting	3	78.70	4
R121	Reconstruction of nipple areola complex by reimplantation of harvested nipple	3	94.80	4
R110	Reduction mammoplasty (female, to include nipple transplantation or grafting) — unilateral	5	322.00	7
R112	Augmentation mammoplasty — unilateral	4	135.40	4
Note:	R118-R112 — Claims for these procedures may require O.H.I.P. authorization (see Surgical Preamble, paragraphs (16), (17) and Preamble, Appendix D.).			

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

Preamble

(1) Corrective splints must be "corrective" to qualify for benefits. The corrective splint listings are not applicable to simple immobilization such as with a Jones bandage or a metal finger splint following soft tissue injury.

(2) The removal of a wire or pin or other device when used for traction or external fixation (**except for the Hoffman apparatus**) in the treatment of a fracture or other orthopaedic procedure is to be included in procedural fee. Removal of devices used for internal fixation may be charged for in addition to the procedural fee.

(3) The fee for total hip replacement also includes denervation of the hip joint and adductor tenotomy.

(4) The fee for obtaining a bone graft is not chargeable in cases of pseudarthrosis repair, fusions or for listings in which bone grafting is included.

(5) **For the supervision of limb fitting and 6 months post-operative care following amputation, charge visit benefits. Amputation with immediate fitting to include supervision of final limb fitting — add 40% (E586).**

Fractures and Dislocations:

(a) The fracture or dislocation fees for services requiring no reduction include the major pre-operative visit. For fractures or dislocations requiring open or closed reduction, the major pre-operative visit i.e. consultation or appropriate assessment may be charged in addition to the listed fees for open or closed reductions.

(b) OPEN REDUCTION shall mean the treatment of a fracture or dislocation by an operative procedure to expose the fracture, or closed intra-medullary fixation, and includes internal or rigid external skeletal fixation except in spinal fractures.

(c) CLOSED REDUCTION shall mean the reduction of a fracture or dislocation by non-operative methods (including traction).

(d) NO REDUCTION shall mean the treatment of a fracture or dislocation by any other method and includes the use of the initial external support.

(e) The stated fee covers full or after treatment **up to 8 weeks** except if additional reductions are necessary or if patient is transferred to another surgeon or if the patient is paraplegic.

(f) In multiple fractures or dislocations, the benefit for the major fracture or dislocation shall be 100% and the fee for the other fractures or dislocations 85%. When no procedural fee is applicable, but when that fracture or dislocation necessitates hospitalization or concurrent care over that demanded by the major injury, a visit fee will apply in addition to other procedural fees.

(g) For repeat reductions (closed or open) for the same fracture of dislocation the full benefit should be claimed for the final reduction and after care — previous reductions by the same surgeon should be claimed at 85%.

(h) **Emergency splinting of fractures in the emergency department should be on the basis of the appropriate visit fee, plus application of cast if appropriate.**

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

(i) Transferred cases —

   (1) When patients are transferred to a chronic or convalescent facility, additional visit fees on a chronic care basis shall be allowed to other than the operating surgeon (and also to the surgeon after 8 weeks)

   (2) When patients are transferred to another physician for after care of fractures and dislocations treated by closed or no reduction, the physician rendering the initial care should charge 75% of the listed fee and the surgeon rendering subsequent care visit fees except where otherwise specified. In cases involving open reduction, the percentage should be 80% for the surgeon providing the initial care.

(j) Paraplegia associated with fractures and dislocations may be billed by charging visit fees after the first 2 weeks of post-operative care in addition to the appropriate procedural fees.

(k) **Pseudarthrosis may be allowed as the appropriate billing fee after the fracture is 4 months old.**

(l) For fractures and dislocations not requiring reduction, visit fees apply unless a specific fee is listed. If the listed fee is less than the consultation fee, the consultation fee may be billed in place of the fracture/dislocation code.

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCOLOSKELETAL SYSTEM

Code	GENERAL FEES	Asst.	Surg. $	Anaes.
	Bone/Fascial/Dermis Grafts			
E551	Autogenous — separate incision		51.50	
E552	— same incision		41.20	
Z242	— different surgeon (I.O.P.)		137.40	
E553	Homogenous — bank		20.60	
	Allograft — donor — 85% of excision fee			
R200	**— cadaver**		103.00	
	Fixation			
E547	Methyl methacrylate (not arthroplasty)		48.10	
E555	**Rigid external fixation, add 40% to closed reduction fee**			
E569	Percutaneous pinning, add 30% to closed reduction fee			
E590	**Rigid external fixation — pseudarthrosis**		54.95	
R267	Removal fixation device — general anaesthetic	3	103.00	4
R268	— local anaesthetic	3	34.30	4
R598	**Removal of extensive external fixation device**		68.70	
Z210	Insertion traction pin — excludes fractures and dislocations (I.O.P.)		24.00	
	Wound Care			
Z783	**Secondary closure**		68.70	
E550	**Closed irrigation during a surgical procedure**		51.50	
E556	Extensive debridement of compound fractures or dislocations — **add 40% to reduction fee**			
R517	**Excision of foreign body**		27.50	
	Electrical Stimulation			
Z250	External or internal (I.O.P.)		137.40	4

Casts (I.O.P.)

Application of plaster casts or corrective splints are not chargeable if applied at the time of surgery (except for the application of a cast brace) or applied during the **first 8 weeks** for fracture or dislocation when a procedural fee is applicable. **The subsequent application of plaster casts is chargeable according to the following schedule. Cost of material is extra.**

Code		Asst.	Surg. $	Anaes.
Z201	Finger		6.90	
Z202	Hand		10.30	4
Z203	Arm, forearm or wrist		17.20	4
Z199	Foot		10.30	4
Z213	Below knee, knee splints (Stove pipe, etc.)		17.20	4
Z211	Whole leg (mid thigh to toes)		20.60	4
Z198	Toes		6.90	4
Z205	Head and torso	3	68.70	4

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCOLOSKELETAL SYSTEM

Code	**GENERAL FEES - Cont'd**	Asst.	Surg. $	Anaes.
Z208	Shoulder spica	3	68.70	4
Z206	Body cast	3	41.20	4
Z207	Hip spica — unilateral	3	68.70	4
Z209	— bilateral	3	85.90	4
Z216	Wedging of casts in other than fracture treatment		6.90	
Z200	Application of Unna's paste		10.30	
Z873	Application of cast brace (must include hinge)		48.10	
Z204	Removal of plaster (not associated with fractures or dislocation **within 8 weeks of initial treatment**)		6.90	
	HAND AND WRIST			
	Amputation			
R606	Phalanx		103.00	4
E582	—each additional		34.30	
R608	Metacarpal or metaphalangeal joint		137.40	4
E583	—each additional		34.30	
R610	Trans. metacarpal 2nd or 5th ray		206.10	4
R611	Hand — all metacarpals	3	206.10	4
R612	Wrist	4	206.10	5
	Arthrodesis			
R465	Finger — thumb	3	171.70	4
R466	Wrist	3	274.75	4
	Arthroplasty			
R437	Wrist — interposition	3	274.75	5
R485	total	6	309.10	6
R479	Removal only	3	137.40	6
R435	Hand — interposition — single	3	171.70	5
R436	— multiple	3	309.10	6
R449	— multiple joints — **total max**	3	549.50	6
R489	Single joint — total	3	206.10	5
R500	Removal only	3	103.00	4
R236	Carpal replacement	3	240.40	5
E564	Revision of arthroplasty — **add 35%**			
	Arthroscopy (I.O.P.)			
Z219	Small joints		44.60	4
E595	Preceding surgery		44.60	
	Arthrotomy			
R409	Finger		103.00	4
R410	Wrist	3	137.40	4

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCOLOSKELETAL SYSTEM

Code	HAND AND WRIST - Cont'd	Asst.	Surg. $	Anaes.
	Aspiration/Injection — see page 97.			
	Biopsy			
Z212	**Bones — punch, x-ray control (I.O.P.)**		51.50	4
Z214	**— open biopsy or taking of bone graft by other than operating surgeon (I.O.P.)**	4	103.00	4
E563	Joint — via arthroscope		6.90	
Z221	— needle (I.O.P.)		34.30	
R409	— open finger		103.00	4
R410	— open wrist	3	137.40	4
Z228	Muscle (I.O.P.)		68.70	4
	Decompression — Denervation			
N290	Decompression median nerve at wrist (carpal tunnel syndrome)	3	106.50	4
N285	Exploration and/or decompression and/or transposition and/or neurolysis of major nerve (excluding sciatic and carpal tunnel nerve)	4	144.20	4
	Drainage			
R219	Incision and drainage — phalanx/metacarpal/carpus	3	92.70	4
R218	**Sequestrectomy — phalanx/metacarpal/carpus**	**3**	**103.00**	**4**
R217	**Saucerization and bone graft phalanx/metacarpal/carpus**	**4**	**171.70**	**4**
R409	Incision and drainage — joint (finger)		103.00	4
R410	— joint (wrist)	3	137.40	4
R534	Tendon sheath	3	82.40	4
	Examination/Manipulation			
	Manipulation — hand/wrist			
Z222	— under general anaesthetic		17.20	4
Note:	without general anaesthetic, see page 104.			
	Excision — Bone			
R316	Proximal row carpectomy	3	240.40	5
R285	Carpal — bone (one)	3	137.40	4
R317	Dorsal exostosis (triquetrum)	3	137.40	4
R286	Radial styloid	3	137.40	4
R283	Phalanx/metacarpal	3	137.40	4
R272	Bone tumour	I.C.	I.C.	I.C.
	Excision — Joint			
R425	Synovectomy/debridement — finger joint	3	171.70	4
R414	— two or more joints	3	274.75	4
R418	Synovectomy/debridement — wrist	3	274.75	4
R492	Radio-ulnar meniscectomy	3	154.50	4
	Excision — Muscle and Tendon			
R522	Muscle — simple		I.C.	I.C.

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCOLOSKELETAL SYSTEM

Code	HAND AND WRIST - Cont'd	Asst.	Surg. $	Anaes.
R523	— complex		I.C.	I.C.
R550	Tendon sheath — single	3	192.30	4
E572	— each additional, add		61.80	1 (max.)
R551	Fascia for Dupuytrens — simple	3	137.40	4
R552	— complex (with or without flaps or grafts)	3	274.75	5
	Excision — Ganglion			
R549	— simple	3	68.70	4
R553	— complex	3	I.C.	4
	Reconstruction — Bone			
R257	Osteotomy — phalanx — terminal		103.00	4
R258	— phalanx — middle proximal		137.40	
	or metacarpal	3	137.40	4
E591	— each additional		27.50	
R321	Pseudarthrosis — phalanx, metacarpal	3	171.70	4
R322	— scaphoid	3	206.10	4
	Reconstruction — Ligaments			
R597	Simple/single repair — wrist	3	137.40	4
R548	Extensive/multiple repair — wrist	3	309.10	4
R601	Metacarpal phalangeal repair	3	171.70	4
	Reconstruction — Nerve — see page 216.			
	Reconstruction — Tendon			
R557	Tenoplasty — one	3	137.40	4
E050	— each additional, add		61.80	
R559	Tendon graft — one	3	206.10	4
E052	— each additional, add		89.30	1 (max.)
R586	Reconstruction of a flexor tendon pulley, per finger		68.70	4
R554	Silicone rod insertion — one	3	206.10	4
E051	— each additional, add		89.30	
R563	Transplant/transfer — single	3	206.10	4
E054	— each additional, add		61.80	1 (max.)
R578	Tendon repair — extensor — single	3	89.30	4
E580	**— each additional, add**		34.30	
R585	Tendon repair — flexor — single	3	151.10	4
E581	**— each additional, add**		61.80	
U.V.C.	Mallet finger — closed		visit fee	
R574	— K-wire		68.70	4
R573	— open	3	103.00	4
U.V.C.	Boutonniere — closed		visit fee	
R577	— open	3	103.00	4
R582	— late	3	171.70	4

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCOLOSKELETAL SYSTEM

Code	HAND AND WRIST - Cont'd	Asst.	Surg. $	Anaes.
	Reconstruction — Extremities			
R602	Pollicization	6	412.10	6
R603	Digital reimplantation involving microvascular and neuro anastosis	8	1,105.90	8
R604	Revision of R602, R603	I.C.	I.C.	I.C.
R605	Reconstruction and plastic repair of traumatically amputated extremities	I.C.	I.C.	I.C.
	Release — tendon			
R556	Tenolysis — **tendon**	3	137.40	4
E599	— each additional **(max. 2)**, add		61.80	
	Tenotomy or fasciotomy (closed) (I.O.P.)			
Z247	— finger — one		34.30	4
Z248	— two		51.50	4
Z249	— three or more		68.70	4
Z231	— palmar or plantar		51.50	4
R536	Tendon release (open) — finger/palm		68.70	4
R537	— wrist	3	89.30	4
E571	**— more than one, add**		89.30	
	Reduction — Fracture			
F004	**Phalanx — no reduction, rigid immobilization**		34.30	
F005	— closed		68.70	4
E558	— each additional		17.20	
F007	— open	4	103.00	4
F008	Metacarpal — no reduction, one or more, rigid immobilization		34.30	
F009	— closed, one or more,		68.70	4
F011	— open	4	103.00	4
E559	— each additional add, (open)		34.30	
F006	Intra-articular — closed		54.95	
F010	— open	3	103.00	4
F012	Bennett's — no reduction, rigid immobilization		34.30	
F013	— closed	3	68.70	4
F015	— open	4	137.40	4
F102	Carpus — no reduction, rigid immobilization		34.30	
F016	— closed, one or more		68.70	4
F017	— open, one or more	4	137.40	4
F018	**Scaphoid — no reduction, rigid immobilization**		34.30	
F019	— open	4	171.70	4
F020	— excision	4	137.40	4
	Reduction — Dislocations			
D001	Finger — closed — one		34.30	4
E576	— each additional add,		6.90	
D003	— open	3	103.00	4
D004	Metacarpal/phalangeal — closed — one		34.30	4
E577	— each additional, add		6.90	
D006	— open	3	103.00	4

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCOLOSKELETAL SYSTEM

Code		Asst.	Surg.	Anaes.
	HAND AND WRIST - Cont'd		$	
D007	Carpal — closed		85.90	4
D008	— open	3	137.40	4
	ELBOW AND FOREARM			
	Amputation			
R613	Through radius and ulna	4	206.10	5
R614	Elbow disarticulation	4	206.10	5
	Arthrodesis			
R466	Elbow	3	274.75	4
	Arthroplasty			
R281	Ulna replacement (lower end)	3	171.70	4
R288	**Implant radial head**	3	144.20	4
R499	**Removal of total replacement**	3	274.75	7
R486	**Complete arthroplasty replacement**	6	377.80	8
R510	Interposition arthroplasty	6	309.10	7
E564	Revision of elbow arthroplasty, **add 35%**			
	Arthroscopy			
Z218	Arthroscopy		68.70	4
E595	Preceding surgery		44.60	
	Arthrotomy			
R445	Elbow, loose body, etc	3	120.20	4
	Aspiration/Injection — see page 97.			
	Biopsy			
Z212	**Bone — needle (I.O.P.)**		51.50	4
Z214	**— open (I.O.P.)**		103.00	4
E563	Joint — via arthroscope		6.90	
R432	**— open**	3	**120.20**	**4**
Z228	Muscle/soft tissue (I.O.P.)		68.70	4
	Decompression/Denervation			
R495	Fasciotomy for compartment syndrome **(not including secondary closure wound)**	3	137.40	4
Z251	Catheter — insertion (I.O.P.)		34.30	
U.V.C.	— monitoring		visit fee	
N285	Exploration and/or decompression and/or transposition and/or neurolysis of ulnar nerve (elbow)	4	144.20	4
R426	Denervation — elbow	3	171.70	4
	Drainage			
R228	Acute, incision and drainage	3	171.70	4
R231	Sequestrectomy	3	206.10	4
R229	Saucerization and bone grafting	3	309.10	4

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCOLOSKELETAL SYSTEM

Code	ELBOW AND FOREARM - Cont'd	Asst.	Surg. $	Anaes.
Z226	Soft tissue or bursa, incision and drainage		68.70	4
R445	Elbow, incision and drainage	3	120.20	4
	Examination/Manipulation			
Z222	Manipulation under general anaesthetic (I.O.P.)		17.20	4
	—without general anaesthetic, see page 104.			
	Excision — Bone			
R287	Radial head	3	137.40	4
R286	Radial styloid	3	137.40	4
R643	**Ulna lower end**	**3**	**137.40**	**4**
R290	Olecranon	3	137.40	4
R291	Olecranon with fascial repair	3	171.70	4
	Excision — Bursae			
R595	**Olecranon**	**3**	**72.10**	**4**
	Excision — Joint Contents			
R421	Synovectomy/capsulectomy/debridement, etc	3	240.40	4
	Excision — Muscles			
R524	Myositis ossificans	4	206.10	5
R517	Foreign body removal		27.50	4
	Excision — Tumours			
R522	Soft tissues — superficial		I.C.	I.C.
R523	— deep		I.C.	I.C.
	Excision — Bone Tumours			
R294	Exostosis	4	103.00	4
R295	Simple excision	4	206.10	4
R293	**Extensive with replacement**	**4**	**480.80**	**6**
	Reconstruction — Bone — Pseudarthrosis			
R323	Radius or ulna	3	206.10	4
R473	**Radius and ulna**	**3**	**291.90**	**4**
	Reconstruction — Bone — Osteotomy			
R259	Radius, ulna	3	206.10	4
R324	Radius, ulna, and reconstruction congenital abnormality, synotosis, etc	3	309.10	4
	Reconstruction — Fascia			
R476	**Repair fascial defects — small**	**3**	**103.00**	**4**
R478	**— large with or without synthetic graft or rotation flap**	**4**	**206.10**	**5**
	Reconstruction — Ligaments			
R597	Simple/single repair	3	137.40	4
R548	Extensive/multiple repair	3	309.10	4

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCOLOSKELETAL SYSTEM

Code	ELBOW AND FOREARM - Cont'd	Asst.	Surg. $	Anaes.
	Reconstruction — Tendons			
R578	Suture extensor tendon — single	3	89.30	4
E580	— each additional, add		34.30	
R585	Suture flexor tendon — single	3	151.10	4
E581	— each additional, add		61.80	
R557	Tenoplasty — single	3	137.40	4
E050	— each additional, add		61.80	
R556	Tenolysis — single	3	137.40	4
E599	— each additional, add		61.80	
R563	Transposition/transplantation/transfer — single	3	206.10	4
E054	—each additional, add		61.80	1 (max.)
R583	**Steindler flexoplasty**	**3**	**240.40**	**5**
	Release			
R519	Muscles and tendons — simple, e.g. tennis elbow	4	68.70	4
R521	— radical, e.g. muscle slide	5	206.10	5
	Reduction — Dislocations			
D009	Elbow joint — closed reduction		48.10	4
D010	— open reduction — acute	3	137.40	4
R400	— repair chronic, recurrent	3	240.40	4
D012	Radial head — closed reduction, pulled elbow		27.50	4
D011	— open reduction — acute	3	137.40	4
R540	— recurrent	3	171.70	6
R558	— late	4	274.75	6
	Reduction — Fractures			
F029	**Epicondyle** — no reduction		48.10	
F037	— closed reduction	3	75.55	4
F038	— open reduction	4	120.20	4
F039	Transcondylar/condylar — no reduction		48.10	
F040	— closed reduction	3	137.40	4
F041	— open reduction	4	240.40	4
F034	Olecranon — no reduction, rigid immobilization		48.10	4
F035	— closed reduction	3	75.55	4
F036	— open reduction	4	137.40	4
F024	Radius and ulna shaft — no reduction, rigid immobilization		48.10	
F025	— closed reduction	3	103.00	4
F026	— open reduction	4	261.00	4
F014	Radius and ulna — **Monteggia** — no reduction, rigid immobilization		48.10	
F022	— closed reduction		103.00	4
F023	**— open reduction of ulna plus closed reduction radial head**	3	144.20	4
F031	Radius or ulna — no reduction, rigid immobilization		48.10	

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCOLOSKELETAL SYSTEM

Code		Asst.	Surg. $	Anaes.
	ELBOW AND FOREARM - Cont'd			
F032	— closed reduction	3	75.55	4
F033	— open reduction	4	137.40	4
	Radius-distal, Colles', Smith's, Barton's, etc.			
F027	— no reduction, rigid immobilization		48.10	
F028	— closed reduction	3	75.55	4
F030	— open reduction	4	137.40	4
F021	Osteochondral — open reduction	4	178.60	5
	SHOULDER/ARM/CHEST			
	Amputation			
R617	Forequarter	10	343.40	15
R616	Shoulder disarticulation	9	274.75	9
R615	High humerus	4	206.10	5
	Arthrodesis			
R467	Shoulder	4	343.40	6
	Arthroplasty			
R438	Humeral prosthesis	4	343.40	6
R487	Total prosthesis	6	549.50	10
R498	Removal prosthesis/no replacement	3	274.75	8
E564	Revision of prosthesis, add 35%			
	Arthroscopy			
Z218	Arthroscopy (I.O.P)		68.70	4
E595	Preceding surgery (same surgeon)		44.60	
	Arthrotomy			
R411	Shoulder	4	137.40	4
	Aspiration/Injection — see page 97.			
	Biopsy			
Z212	**Bones — needle/punch, x-ray control (I.O.P)**		**51.50**	4
Z214	**— open (I.O.P)**	4	**103.00**	4
E563	Joint — via arthroscope		6.90	
R411	— open	4	137.40	4
Z228	Soft tissue — open (I.O.P)		68.70	4
	Drainage			
R222	Humerus/clavicle/scapula — incision and drainage	4	137.40	4
R225	Sequestrectomy	4	206.10	4
R223	Saucerization with bone graft	4	309.10	4
Z226	Bursae/soft tissue		68.70	4
R411	Joint	4	137.40	4
	Examination and Manipulation			
Z223	Manipulation under general anaesthetic (I.O.P) — without general anaesthetic, see page 104.		34.30	4

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCOLOSKELETAL SYSTEM

Code	SHOULDER/ARM/CHEST - Cont'd	Asst.	Surg. $	Anaes.
	Excision — Clavicle or Acromium			
R298	Simple (including ligament)	4	137.40	4
R641	**Major tumour**	I.C.		I.C.
R214	**Malignant tumour with reconstruction**	I.C.		I.C. by Region
	Excision — Humerus			
R292	Head	4	206.10	5
R294	Exostosis	4	103.00	4
R295	Benign tumour	4	206.10	4
R297	Malignant tumour with reconstruction	4	549.50	6
	Excision — Joint			
R422	Synovectomy and debridement	4	343.40	5
R512	Excision of subacromial bursae	3	137.40	4
R522	Muscle/fascia — simple	I.C.	I.C.	I.C.
R523	— complex	I.C.	I.C.	I.C.
R416	Ligament (cuff exploration and acromioplasty)	4	137.40	4
R490	Acromio/sternoclavicular menisectomy	3	137.40	4
	Reconstruction — Pseudarthrosis and osteotomy			
R329	Pseudarthrosis — clavicle	4	171.70	4
R325	— humerus	4	206.10	4
R260	Osteotomy — humerus	4	206.10	4
R298	— clavicle	4	137.40	4
R235	— glenoid	4	206.10	4
	Reconstruction — Nerves see Page 216.			
	Reconstruction — Muscles/Soft Tissues			
R527	Muscle transplant — pectoralis major	6	240.40	6
R521	Muscle/tendon release	5	206.10	5
R526	Release — sternomastoid	5	206.10	5
R353	Scapuloplexy — congenital elevation	6	274.75	6
R568	Trapezius/sternomastoid/transplant	4	240.40	4
R589	Tendon repair-biceps	3	137.40	4
R593	Cuff repair — simple	4	206.10	5
R594	— reconstruction	4	343.40	5
	Reduction — Fractures			
F047	Tuberosity — no reduction		48.10	
F048	— closed reduction	3	85.90	4
F049	— open reduction (**without cuff tear**)	4	206.10	4
F053	Neck without dislocation of head — no reduction		48.10	
F054	— closed reduction		85.90	4
F055	— open reduction	5	206.10	6
F050	Neck with dislocation of head — no reduction		48.10	

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCOLOSKELETAL SYSTEM

Code	SHOULDER/ARM/CHEST - Cont'd	Asst.	Surg. $	Anaes.
F051	— closed reduction	3	130.50	4
F052	— open reduction	5	240.40	6
F042	Shaft — no reduction		48.10	
F043	— closed reduction	3	103.00	4
F044	— open reduction	4	206.10	4
U.V.C.	Clavicle — no reduction		visit fees	
F110	— closed reduction with anaesthetic	3	44.60	4
F118	— open reduction	4	137.40	4
F119	Scapula — no reduction		48.10	
F120	— closed reduction with anaesthetic	3	82.40	4
F121	— open reduction	4	171.70	5
F122	Sternum — no reduction		48.10	
F123	— closed reduction		82.40	
F124	— open reduction-**pleura open**	9	I.C.	13
F125	— pleura closed	4	I.C.	4
U.V.C.	Ribs — no reduction		visit fees	
F130	— complicated-pleura open	9	I.C.	13
F131	-pleura closed	4	I.C.	4
	Reduction — Dislocations			
D014	**Acromio-clav./sterno-clav.**			
	— no reduction		**48.10**	
D025	— closed with anaesthetic	4	103.00	4
D023	— open reduction	4	137.40	4
R596	— open reduction late	4	206.10	4
	Glenohumeral joint — closed reduction			
D015	— without anaesthetic		34.30	
D016	— with anaesthetic		68.70	4
D017	— open reduction — early	4	206.10	6
R472	**— late**	**4**	**412.10**	**7**
R401	— recurrent	5	274.75	5
	SKULL AND MANDIBLE			
	Arthroplasty			
R433	Temporo-mandibular joint-unilateral	5	240.40	5
	Biopsy (I.O.P)			
Z869	Bones — punch, simple		27.50	4
Z870	— punch, x-ray control		68.70	4
Z242	— open	4	137.40	4
	Drainage			
R256	Skull and mandible-osteomyelitis	7	I.C.	7
	Excision			
R272	Bone — Tumour	I.C.	I.C.	I.C.

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCOLOSKELETAL SYSTEM

Code	SKULL AND MANDIBLE - Cont'd	Asst.	Surg. $	Anaes.
R278	Maxilla. with extenteration of orbit and skin graft	4	360.60	7
R279	Maxilla advancement	4	298.80	8
R280	Mandible	4	240.40	7
R284	Mandibular condyle	4	185.45	5
R428	Tempero-mandibular meniscectomy	5	171.70	5
	Reconstruction			
R334	Mandible with bone graft — partial	4	332.70	10
R335	— complete	4	498.00	10
R354	Interdental wiring for tempro-mandibular joint disorder including removal of wires	3	116.80	5
R531	Facial paralysis — static slings	4	206.10	5
R532	— dynamic slings	4	271.30	6
R533	Composite repair for facial paralysis, plication of paralized muscles, and resection for, paralysis of over active muscles	4	346.90	7
E597	— with meloplasty, add		58.40	
R375	Major congenital abnormalities affecting the face and skull-not otherwise listed	I.C.	I.C.	I.C.
R376	Hypertelorism correction — intracranial approach	12	1,312.90	25
R377	— suocranial approach	12	976.65	25
R378	Total maxillary advancement — Le Fort III osteotomy with bone grafts	12	1,037.50	25
R379	Lower maxillary osteotomy and advancement (simple) — Le Fort osteotomy with bone grafts	10	493.70	20
R380	Lower maxillary osteotomy and advancement — dental arch in two segments	10	654.70	20
R381	Lower maxillary osteotomy and advancement (complex) — dental arch in three or more segments	10	772.70	20
R382	Dento-alveolar osteotomy-Kole or Wassmund procedure	6	329.10	10
R383	Dento-alveolar osteotomy (complex) — anterior or posterior movement of dental segments in two or more sections	6	436.45	10
R384	Mandible osteotomy for retrognathia or prognathism (one or more stages)	6	472.20	10
E588	— when combined with apertognathia or lateratognathia, add		110.90	
Z239	Application for dental arch bars for facial osteotomies — one arch bar (I.O.P)	4	57.20	4
Z240	two arch bars (I.O.P)	4	110.90	4
	Genioplasty for facial reconstruction			
R386	— one step advancement	6	110.90	10
R387	— two step advancement	6	135.90	10

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCOLOSKELETAL SYSTEM

Code	SKULL AND MANDIBLE - Cont'd	Asst.	Surg. $	Anaes.
R388	— three step advancement	6	193.20	10
R389	Le Fort II maxillary osteotomy and advancement with bone grafts	10	772.70	20
R390	Peri-orbital correction of Treacher-Collins Syndrome, with rib and iliac grafts	10	876.50	20
R391	Correction of unilateral orbital dystopia — total repositioning one orbit-intracranial approach	12	876.50	25
R392	— subtotal repositioning one orbit — extracranial approach	10	654.70	20
R393	Complete forehead advancement	12	440.00	25
R394	Cranial vault reconstruction for oxycephaly, brachycephaly, turricephaly	10	851.40	20
R395	Reconstruction of glenoid fossa, zygomatic arch and temporal bone (Obwegeser technique)	10	812.10	20
R396	Construction of absent condyle and ascending ramus in hemi-facial microsomia	6	415.00	10
R397	Facial bone reconstruction by onlay multiple bone grafts	I.C.	I.C.	I.C.
R398	Transnasal canthopexy	3	225.40	6
R399	Lateral canthoplasty	3	171.70	6
E557	**— when R398 or R399 are done in conjunction with another procedure(s), add**		57.20	
R629	**Reconstruction of skull**	**I.C.**	**I.C.**	**I.C.**
	Reduction — Fractures			
	Orbit			
	Open reduction rim/wall fracture			
E173	— zygomatic fracture dislocation	4	185.45	6
E174	— blowout fracture of floor	4	216.40	6
E175	— secondary repair by combined or orbital approach	4	319.40	6
F143	Middle 1/3 facial	5	288.50	6
F144	Cranial-facial separation	5	364.00	8
	Nasal bones (including septum)			
U.V.C.	— no reduction		visit fees	
F136	— closed reduction		68.70	4
F137	— open reduction		168.30	5
	Mandible			
U.V.C.	— no reduction — no wiring of teeth		visit fees	
F138	— closed reduction-including wiring of teeth		171.70	5
F139	— open reduction (may include wiring of teeth) — one side	4	230.10	5
F146	complicated	I.C.	I.C.	I.C.
F140	— removal of interdental wire			4
	Maxilla, malar bone			
U.V.C.	— no reduction		visit fees	

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCOLOSKELETAL SYSTEM

Code		Asst.	Surg.	Anaes.
Code	**SKULL AND MANDIBLE - Cont'd**		$	
F150	— closed reduction and dental wiring		171.70	5
F141	— open reduction — simple	4	99.60	5
F142	— with wiring and local fixation	5	264.40	6
	Reduction — Dislocations			
D062	Temporo-mandibular joint — closed reduction		34.30	4
D063	— open reduction	5	171.70	5
	SPINE			
	Arthrodesis			
R459	Anterior or posterior fusion of one level	7	274.75	10
R419	Fusion of C1-2	8	357.20	10
E573	Each additional level (to a max. of 2 additional) Fusion with other procedure(s)		68.70	
E567	**By same surgeon** — one level, add		178.60	
E568	— multiple levels, add		233.50	
E929	— anterior cervical interbody fusion, per level, add		54.95	
R493	Fusion by different surgeon — one level,		212.90	
R494	— multiple levels,		250.70	
R541	**— anterior cervical interbody fusion, per level**		82.40	
E574	Repeat fusion, to any fusion, add		161.40	
E548	With instrumentation, add		106.50	
	Aspiration/Injection — see page 97.			
	Biopsy			
Z868	Bone — needle (I.O.P.)	4	103.00	4
R274	— open — posterior approach	4	171.70	7
R275	— anterior approach	6	219.80	8
Z228	Soft tissue — open (I.O.P.)		68.70	4
	Decompression — Anterior, Anterolateral or Posterolateral			
R447	Simple anterior cervical discectomy	8	250.70	10
R452	Simple anterior lumbar discectomy	6	357.20	10
N182	Anterior cervical spinal cord or nerve root decompression, including removal of disc or vertebral body, single disc level		412.10	
N186	Anterolateral or posterolateral decompression, lumbar or thoracic spine, single disc level		748.70	13
Note:	For thoracotomy or laparotomy by separate surgeon use M137 (page 160), S312 (page 187.)			
E928	Each additional disc level decompressed — to R447, R452, N182, N186 add		178.60	

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCOLOSKELETAL SYSTEM

Code	SPINE - Cont'd	Asst.	Surg. $	Anaes.
	Decompression — Posterior			
R451	Cervical hemilaminectomy for disc disease, with or without foraminotomy	6	394.95	10
R457	Lumbar hemilaminectomy for disc disease including removal of soft disc or osteophyte	6	288.50	8
E565	Multiple levels to R451, R457, per additional level, add		54.95	
E566	Bilateral, to R451, R457 add		54.95	
N185	Posterior laminectomy one or two levels, cervical, thoracic, lumbar		412.10	
N337	Repeat posterior decompression or reopening of posterior decompression, more than six months after original procedure, includes foraminotomy, discectomy or neurolysis	8	446.50	10
E914	Laminectomy extending over 3 or more laminae, to N185, N337 add		106.50	
E915	**Foraminotomy, to R457, N185 and N337 per foramen decompressed, add**		54.95	
E907	Opening of dura (**associated with any decompressive procedure**), add		106.50	
E926	Spinal duroplasty (**applies to any spinal procedure**), add		161.40	
	Drainage			
R251	Bone — incision and drainage only	4	206.10	4
R234	Sequestrectomy — anterior	7	446.50	10
R254	— posterior	4	274.75	4
	Saucerization with bone grafting			
R270	— anterior	6	549.50	10
R252	— posterior	4	274.75	5
Z226	Soft tissue		68.70	4
	Examination/Manipulation			
Z215	**Manipulation under general anaesthetic (I.O.P.)**		27.50	4
	— without general anaesthetic, see page 104.			
	Excision — Bone			
R373	Spinous process	4	171.70	4
R374	Lamina or transverse process	6	274.75	8
R450	Part of body or pedicle	6	412.10	8
R455	Total body (includes replacement)	9	686.90	13
	Excision — Muscle/Soft Tissue			
R634	**Tumours — simple**	I.C.	I.C.	I.C.
R635	**— complex**	I.C.	I.C.	I.C.
	Reconstruction — Osteotomy (includes fixation/fusion)			
R303	Anterior — via chest	9	549.50	13
R636	**— via abdomen**	**9**	**549.50**	**9**

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCOLOSKELETAL SYSTEM

Code		Asst.	Surg.	Anaes.
	SPINE - Cont'd		$	
R271	— via chest and abdomen	9	618.20	13
R296	Posterior	9	515.20	9
E549	— with rib or transverse release, add		89.30	
R310	Circumferential	9	824.25	9
R264	Cervical	10	824.25	12
	Instrumentation — Deformities Anterior (Dwyer etc. includes fusion/discectomy)			
R350	— via chest or abdomen	9	1,030.30	17
R359	— via chest and abdomen	9	1,133.35	17
R362	Posterior (Harrington) — with fusion	8	686.90	12
R347	— without fusion	8	515.20	12
E554	— with **posterior** osteotomy, add		103.00	
R371	Luque procedure — with fusion	8	858.60	12
R370	— without fusion	8	618.20	12
R369	Readjustment of instrumentation		103.00	4
R461	Removal of — anterior instrumentation	8	206.10	8
R348	— posterior instrumentation	8	137.40	8
	Revision of entire instrumentation			
R346	— with fusion	8	858.60	12
R336	— without fusion	8	686.90	12
R365	Electrical stimulation	8	412.10	10
R366	— with muscle stripping of spine	8	515.20	12
R367	Repair or replacement of electrodes	8	137.40	10
R368	Removal of electrodes	8	137.40	8
R345	Definitive care/casts/fusion for scoliosis	8	618.20	9
R464	Muscle stripping spine prior to surgery	6	137.40	8
R361	Halo traction prior to surgery (complete care)	3	206.10	4
	Anterior release including Halo traction			
R358	— via chest or abdomen	9	412.10	13
R357	— via chest and abdomen	9	480.80	13
R356	Localiser cast		68.70	4
	Reduction — Fractures or Fracture Dislocations			
U.V.C.	Fracture of spine without procedure		visit fees	
Z236	Skull calipers (I.O.P.)		34.30	
Z241	Halo traction (I.O.P.)		54.95	
Z246	Reapplication of Halo traction (I.O.P.)		34.30	
E562	Counter traction pins or vest — add		72.10	
F103	Closed reduction	5	127.10	5
F105	Open reduction — **posterior approach**	5	212.90	5
F107	— **anterior approach**	5	250.70	10
E913	**With spinal cord injury, add when total care by operating surgeon**		**106.25**	
E927	With irrigation. including opening of dura, add to **fractures when combined with decompressive procedures**		212.90	
E567	Fusion by same surgeon — one level, add		178.60	
E568	— two or more levels, add		233.50	

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCOLOSKELETAL SYSTEM

Code	**SPINE - Cont'd**	Asst.	Surg. $	Anaes.
	Fusion by different surgeon			
R493	— one level, add		212.90	
R494	— two or more levels, add		250.70	
E548	With instrumentation, add		106.50	
	PELVIS AND HIP			
	Amputation			
R631	Hemipelvectomy — hindquarter	10	549.50	15
R630	Hip disarticulation	10	343.40	10
	Arthrodesis			
R469	Sacro-iliac joint	5	274.75	5
R514	Symphysis pubis	5	274.75	6
R470	Hip	5	549.50	8
	Arthroplasty			
R439	Unipolar	6	343.40	8
R440	Bipolar	8	549.50	8
R442	Surface replacement	8	686.90	8
E589	Bone graft to acetabulum, add		68.70	
E593	Acetabular reconstruction (extensive, including bone grafts), add		137.40	
E564	Revision, **add 35%**			2
R481	Reattachment of greater trochanter (late)	6	206.10	8
R443	Removal only — non cemented	3	274.75	8
R488	— cemented	3	343.40	8
	Arthroscopy			
Z218	Hip joint (I.O.P.)		68.70	4
E595	Preceding surgery (**same surgeon**)		44.60	
	Arthrotomy			
R547	**Sacro-iliac joint**	**5**	**206.10**	**6**
R415	Hip — with removal of loose body	5	206.10	6
	Aspiration/Injection — see page 97.			
	Biopsy			
Z212	Bone — punch needle (I.O.P.)		51.50	4
Z217	— under general anaesthetic (I.O.P.)		51.50	5
Z214	— open (I.O.P.)		103.00	4
E563	Joint — via arthroscope		6.90	
R415	— open	5	206.10	6

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCOLOSKELETAL SYSTEM

Code	PELVIS AND HIP - Cont'd	Asst.	Surg. $	Anaes.
Z228	Soft tissue — open		68.70	4
	Denervation/Decompression			
N293	Decompression of lateral femoral cutaneous nerve	4	106.20	4
N179	Exploration and/or decompression of sciatic nerve	6	302.20	6
N285	Exploration and/or decompression and/or transposition and/or neurolysis of major nerve	4	144.20	4
N284	Decompression by excision of first rib and/or cervical rib to include scalenotomy when required	6	267.90	6
R427	Denervation of hip	4	274.75	5
	Drainage			
R269	Bone, incision and drainage	3	206.10	4
R249	Sequestrectomy	4	274.75	4
R250	Saucerization and bone graft	4	480.80	5
Z226	Bursae/soft tissue (I.O.P.)		68.70	4
R415	Joint	5	206.10	6
	Examination/Manipulation			
Z252	**Manipulation — under general anaesthetic**		**27.50**	**4**
	— without general anaesthetic see page 104.			
	Excision — Bone			
R639	**Simple cyst, etc**	**4**	**240.40**	**4**
R330	Major resection tumour	4	343.40	6
R216	Radical resection tumour	8	549.50	8
F115	Coccyx	4	137.40	4
R315	Head and neck, femur	4	343.40	6
	Excision — Muscle			
R522	Simple	I.C.	I.C.	I.C.
R523	Complex	I.C.	I.C.	I.C.
R524	Myositis	4	206.10	5
	Excision — Joint			
R423	Synvectomy/debridement	5	377.80	5
	Excision — Bursae			
R590	GT trochanteric/ischial	3	137.40	4
	Reconstruction — Pseudarthrosis			
R364	Pelvis	I.C.	412.10	I.C.
R328	Hip	6	343.40	6
	Reconstruction — Osteotomy			
R265	Pelvis — infant	8	274.75	8
R273	— other	8	412.10	8
R263	Hip	5	412.10	7

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCOLOSKELETAL SYSTEM

Code	PELVIS AND HIP - Cont'd	Asst.	Surg. $	Anaes.
	Reconstruction — Muscle/Tendon			
R521	Muscle release	5	206.10	5
Z232	Closed **abductors** — tenotomy (I.O.P.)		34.30	4
Z233	Open **abductors** — tenotomy (I.O.P.)		68.70	4
R545	Iliopsoas — tenotomy	5	171.70	5
	Reconstruction — Tendon Transfer			
R570	Iliopsoas	5	412.10	6
R569	Abductor	5	274.75	6
	Reduction — Fractures			
U.V.C	Coccyx — no reduction		visit fees	
F115	— excision	4	137.40	4
U.V.C.	Pelvic ring — no reduction		visit fees	
F134	— closed reduction	3	343.40	4
F135	— open reduction	6	480.80	8
U.V.C.	Sacrum — no reduction		visit fees	
U.V.C.	Femoral neck — no reduction		visit fees	
F098	— closed reduction/traction	3	274.75	4
	Femoral neck			
F099	— open reduction — pin only	6	274.75	8
F100	— pin and plate	6	377.80	8
F101	— **prim prosthesis**	6	309.10	8
R600	**— delayed/staged graft**	**6**	**206.10**	**8**
	Slipped epiphysis			
R607	**— closed reduction/traction**	**6**	**274.75**	**8**
R642	**— closed reduction/internal fixation**	**6**	**274.75**	**8**
R627	**— open reduction/fixation**	**6**	**412.10**	**8**
	Reduction — Dislocations			
U.V.C.	Acetabulum — no reduction		visit fees	
D051	— closed reduction	4	206.10	4
D052	— open reduction — lips	7	343.40	7
D046	— one pillar	4	686.90	7
D047	— two pillars	8	1,030.30	12
D042	Hip — closed		206.10	4
D043	— open	7	274.75	7
R628	**— late**	**7**	**549.50**	**10**
D059	Sacro-iliac — closed traction, spica etc		343.40	5
D060	— open	5	480.80	5
U.V.C.	Sacro-coccygeal — closed		visit fees	
D061	— open, removal of coccyx	5	137.40	5
R404	Congenital hip — closed (includes tenotomy and cast)		137.40	4
R405	— repeat (includes cast)		68.70	4
R406	— open (includes tenotomy and arthrotomy)	7	274.75	7

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCOLOSKELETAL SYSTEM

Code	FEMUR	Asst.	Surg. $	Anaes.
	Amputation			
R625	Gritti-Stokes or Callander	5	206.10	5
R626	Through femur	5	206.10	5
	Biopsy (I.O.P.)			
Z869	Bone — core, punch		27.50	4
Z870	— x-ray control/general anaesthetic		68.70	4
Z242	— open	4	137.40	4
Z228	Soft tissue — open		68.70	4
	Drainage			
R242	Incision and drainage, bone	3	206.10	4
R245	Sequestrectomy	3	274.75	4
R243	Saucerization and graft	5	480.80	6
Z226	Soft Tissue		68.70	4
	Excision — Bone			
R314	Simple cyst/exostosis	4	171.70	4
R330	Bone tumor — simple	4	343.40	6
R216	— with construction/graft	8	549.50	8
	Excision — Muscle			
R522	Simple	I.C.	I.C.	I.C.
R523	Complex	I.C.	I.C.	I.C.
R328	**Reconstruction — Pseudarthrosis**	**6**	**343.40**	**6**
	Reconstruction — Fascial			
R632	Simple	3	137.40	4
R633	Complex with or without synthetic graft or rotation flap	4	274.75	5
	Reconstruction — Osteotomy			
R262	Femoral shaft	4	412.10	5
R215	Supracondylar	4	274.75	6
	Reconstruction — Leg Length Operations			
R333	Femoral shortening — all types	4	343.40	4
R332	Femoral lengthening — all types	4	343.40	4
R340	Femoral epiphysiodesis	4	206.10	5
R341	Tibial and femoral epiphysiodesis	4	309.10	5
R343	Femoral stapling	4	171.70	4
R344	Tibial and femoral stapling	4	274.75	5
	Reconstruction — Muscles/Tendons			
R589	Quadriceps repair — simple	3	137.40	4
R587	— reconstructive	3	274.75	4
R530	Quadricepsplasty — all types	4	274.75	5
R561	Ilio-tibial band	3	109.90	4
R543	Tenotomy of hamstrings — single	3	85.90	4
R562	— multiple	3	103.00	4
R557	Lengthening of hamstrings — single	3	137.40	4
E050	— each additional, add		61.80	

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCOLOSKELETAL SYSTEM

Code	**FEMUR - Cont'd**	Asst.	Surg. $	Anaes.
R571	Tendon or muscle transfer	3	206.10	5
E049	— each additional, add		61.80	1 (max.)
R524	Excision of myositis	4	206.10	5
	Reducton — Fractures			
	Femoral shaft/supracondylar			
U.V.C.	— no reduction — cast — bed rest		visit fees	
F093	— closed reduction — traction — infant		137.40	4
F094	— child	3	171.70	4
F095	— adult or adolescent	3	274.75	4
F096	— open reduction	6	343.40	8
	KNEE			
	Amputation			
R625	Through knee — disarticulation	5	206.10	5
	Arthrodesis			
R468	Knee	3	274.75	5
	Arthroplasty			
R509	Patellar arthroplasty	3	171.70	5
	Hemi-arthroplasty			
R482	— single component (e.g. MacIntosh)	6	206.10	6
R483	— double component (e.g. Marmar)	6	309.10	6
R44[illegible]	Total replacement/both compartments	8	480.80	8
E598	With associated patellar replacement or patelloplasty, add		68.70	
R496	Removal of hemi-arthroplasty — without replacement	4	171.70	5
R497	Removal of total arthroplasty — without replacement	4	223.20	5
E564	Revision of arthroplasty, **add 35%**			
	Arthroscopy			
Z218	Diagnostic arthroscopy		68.70	4
E595	Preceding surgery of joint		44.60	
	Arthrotomy			
R412	Knee	3	137.40	4
R413	Osteochondritis dessicans with drilling and/or internal fixation	3	178.60	4
	Aspiration — see listing on page 97.			
	(Diagnostic & Therapeutic Procedures)			
	Biopsy			
Z870	Bone/Joint — needle (I.O.P.)		68.70	4
Z242	— open (I.O.P.)	4	137.40	4
E563	— via arthroscope		6.90	
Z228	Soft Tissue — open (I.O.P.)		68.70	4
	Denervation/Decompression			
R426	Denervation of knee	3	171.70	4
N296	Denervation of gastrocnemius	4	123.60	4

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCOLOSKELETAL SYSTEM

Code	KNEE - Cont'd	Asst.	Surg. $	Anaes.
	Drainage			
Z226	Soft Tissue (I.O.P.)		68.70	4
R412	Joint	3	137.40	4
	Examination/Manipulation			
Z222	Manipulation — under general anaesthetic (I.O.P.)		17.20	4
	— without general anaesthetic see page 104.			
	Excision			
R431	Baker's cyst — simple	3	89.30	4
R434	— extensive	4	171.70	6
R501	Cysts of meniscus	3	89.30	4
R429	Meniscectomy	3	171.70	4
R417	Debridement of joint without synovectomy	3	206.10	4
R424	Synovectomy	3	343.40	5
R506	Prepatellar bursae	3	89.30	4
R312	Patella — simple	3	154.50	4
R313	— with repair	3	223.20	4
	Reconstruction — Meniscus			
R508	Suturing of meniscus	3	171.70	5
	Reconstruction — Muscles/Tendons			
R584	**Tenoplasty — one**	**3**	**103.00**	**4**
E050	— each additional, add		61.80	
R589	Suture of patellar or quadriceps tendon — early	3	137.40	4
R587	— late	3	274.75	4
R571	Transplant of tendon — single	3	206.10	5
E049	— each additional, add		61.80	1 (max.)
Z237	Tenotomy — closed — one		34.30	4
Z238	— multiple		51.50	4
R564	Tenotomy — open — one	3	68.70	4
R566	— multiple	3	103.00	4
R516	Release patellar retinaculum	5	103.00	5
	Reconstruction — Ligaments			
R599	Ligaments — simple/one	3	261.00	4
R542	— extensive/multiple (including synthetics .	4	398.40	6
R484	— synthetic anterior/posterior cruciate	6	343.40	6
R539	— removal of synthetics	4	171.70	4
	Reduction — Fractures			
F085	Patella — no reduction		48.10	
F087	— open reduction-excision and/or simple repair	4	154.50	4
F088	— excision and fascial repair	4	223.20	5
F021	**Osteochondral fracture — open reduction**	4	178.60	5

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCOLOSKELETAL SYSTEM

Code	KNEE - Cont'd	Asst.	Surg. $	Anaes.
	Reductions — Dislocations			
D038	Knee — closed reduction		137.40	4
D039	— open reduction	5	206.10	5
D040	Patella — closed reduction — without anaesthetic		41.20	
D031	— with anaesthetic		68.70	4
D041	— open reduction — early		206.10	5
R255	**— late**	**4**	**343.40**	**6**
R403	— recurrent	4	274.75	5
R515	Congential dislocation — knee (open)	4	343.40	6
	FIBULA and TIBIA			
	Amputation			
R624	Tibia/fibula	5	206.10	5
	Biopsy (I.O.P.)			
Z870	Bone — simple — punch		68.70	4
Z242	— open	4	137.40	4
Z228	Soft tissue — open		68.70	4
	Decompression/Denervation			
R495	Decompression of fascial compartments	3	137.40	4
Z251	Catheter insertion (I.O.P.)		34.30	
U.V.C	Monitoring of pressure monitoring device		visit fees	
N184	Decompression of posterior Tibial or common perineal nerve	4	116.80	4
	Drainage			
R237	Incision and drainage, bone	3	171.70	4
R239	Sequestrectomy	3	206.10	4
R238	Saucerization and bone grafting	3	309.10	4
Z226	Soft tissue		69.10	4
	Excision			
R311	Exostosis/cyst	3	137.40	4
R210	Fibular head	3	137.40	4
R295	Tumour — simple	4	206.10	4
R253	**— extensive with repair**	I.C.	I.C.	I.C.
R522	Muscle/soft tissue — simple	I.C.	I.C.	I.C.
R523	— complex	I.C.	I.C.	I.C.
	Reconstruction — Pseudarthrosis			
R326	Tibia/fibula	4	240.40	5
R327	By-pass Fibular graft	4	274.75	6
R372	Congenital pseudarthrosis	4	343.40	6
	Reconstruction — Osteotomy			
R261	Tibia and fibula — child	3	171.70	4
R266	— adult or adolescent	3	274.75	4
R403	Tuberosity (Macquet)	4	274.75	5

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCOLOSKELETAL SYSTEM

Code	FIBULA and TIBIA - Cont'd	Asst.	Surg. $	Anaes.
	Reconstruction — Leg Length Operations			
R331	Tibial lengthening	4	274.75	4
R458	Tibial shortening	4	274.75	4
R341	Tibial and femoral epiphysiodesis	4	309.10	5
R339	Tibial epiphysiodesis	4	206.10	5
R342	Tibial stapling — one side	4	137.40	4
R460	— both sides	4	171.70	4
R344	Tibial and femoral stapling	4	274.75	5
	Reduction — Fractures			
	Tibia with or without fibula			
F078	— no reduction, rigid immobilization		82.40	
F079	— closed reduction	3	137.40	4
F080	— open reduction — shaft	4	240.40	5
F081	— plateau	4	274.75	5
F082	Fibula — no reduction, rigid immobilization		48.10	
F083	— closed reduction		68.70	4
F084	— open reduction	4	120.20	4
	FOOT AND ANKLE			
	Amputation			
R620	Metatarsal/phalanx disarticulation	4	103.00	4
E585	— each additional		34.30	
R621	Ray (single)	4	154.50	4
R623	Symes	5	206.10	5
R622	Transmetatarsal/transtarsal	4	154.50	4
R619	Terminal Symes	4	103.00	4
	Arthrodesis			
R466	Ankle	3	274.75	4
R471	Interphalangeal	3	103.00	4
E575	— each additional		27.50	
R477	Metatarsophalangeal	3	175.15	4
R474	Midtarsal/subtalar	3	240.40	4
R513	Triple	3	274.75	5
R475	Pan-talar, one stage	3	508.30	6
	Arthroplasty			
R485	Ankle — total replacement	6	309.10	6
R479	Removal of prosthesis without replacement	3	137.40	6
R456	Metatarsophalangeal interposition — single	3	103.00	5
E538	— each additional, add		27.50	
R453	Metatarsophalangeal (Swansons. etc.)	3	206.10	5
R454	— multiple	3	274.75	6
R500	Removal — prosthesis without replacement	3	103.00	4
E564	Revision of arthroplasty, **add 35%**			

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCOLOSKELETAL SYSTEM

Code	FOOT AND ANKLE - Cont'd	Asst.	Surg. $	Anaes.
	Arthroscopy			
Z218	Ankle without surgery		68.70	4
Z219	Other foot joints		44.60	4
E595	Ankle followed by surgery		44.60	
E630	**Other foot joints with surgery**		44.60	
	Arthrotomy			
R503	Ankle — removal of loose body, etc	3	120.20	4
E539	— with osteotomy of malleolus, add		85.90	
R504	Mid Tarsals	3	103.00	4
R505	Metatarsal/phalangeal	3	103.00	4
	Aspiration — see listings on page 97.			
	Biopsy			
Z869	Bone — needle — punch (I.O.P.)		27.50	4
Z870	— punch — under general anaesthetic		68.70	4
Z242	— open	4	137.40	4
E563	Joint — via arthroscope		6.90	
R409	— open		103.00	4
Z228	Soft tissue — open (I.O.P.)		68.70	4
	Drainage			
R220	Incison and drainage — bone	3	92.70	4
R201	**Sequestrectomy**	**4**	**137.40**	**4**
R202	**Saucerization and bone graft**	**4**	**274.75**	**4**
Z226	Bursae (I.O.P.)		68.70	4
R503	Joints	3	120.20	4
Z228	Soft Tissue (I.O.P.)		68.70	4
	Examination/Manipulation			
Z222	— under general anaesthetic		17.20	4
	— without general anaesthetic, see page 104.			
	Club foot, etc. — manipulation and cast/strapping			
Z235	— without anaesthetic		13.70	
Z224	— with anaesthetic		27.50	4
	Excision — Bone			
R299	Phalanx	3	75.55	4
R309	Metatarsal head	3	103.00	4
E587	— each additional		27.50	
R305	Accessory navicular (scaphoid)	3	89.30	4
R302	Bunion/Bunionette	3	89.30	4
R307	Calcaneal spur	3	85.90	4
R282	Exostosis (dorsal, subungal)	3	51.50	4
R308	Os calcis, talus	3	206.10	4

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCOLOSKELETAL SYSTEM

Code	FOOT AND ANKLE - Cont'd	Asst.	Surg.	Anaes.
			$	
R301	Sesamoid, one or both	3	85.90	4
R306	Tarsal bar	3	154.50	4
R272	Tumour (foot)	I.C.	I.C.	I.C.
R300	Tumour (phalanx) — simple	3	137.40	4
R272	— complex	I.C.	I.C.	I.C.
	Excision — Joint			
R420	Ankle synovectomy	3	206.10	4
R425	Metatarsophalangeal synovectomy — one	3	171.70	4
R414	— two or more	3	274.75	4
	Excision — Soft Tissue			
R549	Ganglion — simple	3	68.70	4
R553	— complex	3	I.C.	4
R506	Bursa	3	89.30	4
R551	Fascia (Dupuytrens) — partial	3	137.40	4
R552	— complete	3	274.75	5
R522	Muscle — simple		I.C.	I.C.
R523	— complex		I.C.	I.C.
	Reconstruction — Pseudarthrosis			
R363	Malleoli	3	178.60	4
R321	Tarsals/metatarsals/phalanx	3	171.70	4
	Reconstruction — Osteotomy			
R259	Os calcis	3	206.10	4
R276	Metatarsals and phalanx	3	103.00	4
E596	— each additional, add		27.50	
R277	Midtarsal/tarsal	3	171.70	4
R337	Shortening metatarsal — one	4	137.40	4
R338	— two or more	4	171.70	4
	Reconstruction — Forefoot			
R430	Claw and hammer toe	3	96.20	4
E594	— each additional hammer toe, add		27.50	
R304	Hallux Valgus — Mayo, Keller	3	137.40	4
R355	— Joplin, McBride	3	188.90	4
R360	Major forefoot reconstruction — max.	3	274.75	5
R446	Overlapping 5th toe	3	96.20	4
	Reconstruction — Club Foot			
R408	Posterior or medial release	4	206.10	4
R448	Posteromedial release, lateral shortening, tendon transfers and fusion	4	274.75	4
R546	Plantar fascio release (Steindler)	3	68.70	4
	Reconstruction — Ligaments			
R597	Ankle — simple/one	3	137.40	4
R548	— extensive/multiple	3	309.10	4

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCOLOSKELETAL SYSTEM

Code	FOOT AND ANKLE - Cont'd	Asst.	Surg. $	Anaes.
	Reconstruction — Tendons			
R640	**Exploration — tendon sheath**	3	89.30	4
	Tenolysis — extensive release			
R556	— one	3	137.40	4
E599	— each additional, add		61.80	
	Tendon transfer foot and ankle			
R565	— single	3	171.70	4
E055	— each additional, add		61.80	**1 (max.)**
R572	Tenodesis	3	171.70	4
R560	Graft	4	171.70	4
E053	— each additional, add		61.80	
R557	Lengthening or shortening — one	3	137.40	4
E050	— each additional, add		61.80	
R578	Suture extensor tendon — one	3	89.30	4
E580	— each additional, add		34.30	
R585	Suture flexor tendon — one	3	151.10	4
E581	— each additional, add		61.80	
R589	Achilles tendon repair — early	3	137.40	4
R587	— late	3	274.75	4
R579	Tenotomy (open) — one toe		61.80	4
R581	— more than one toe		137.40	4
Z229	(closed) — one toe (I.O.P.)		34.30	4
Z243	— more than one toe (I.O.P.)		68.70	4
	Achilles or tibialis anterior/posterior tenotomy			
R544	— open	3	68.70	4
R555	— closed		34.30	4
	Reduction — Fractures			
F074	Ankle — no reduction, rigid immobilization		48.10	
F075	— closed reduction	3	103.00	4
F076	— open — one malleolus	4	154.50	4
F077	— **multiple malleoli or ligaments**	4	206.10	5
	Ankle fracture with tibial Plafond burst			
F104	— closed	3	171.70	4
F108	— open	4	257.60	6
	Metatarsus — no reduction			
F061	— one or more		34.30	
F062	— with rigid immobilization		48.10	
F063	— closed reduction — one or more	3	61.80	4
F064	— open reduction — one	4	85.90	4
F065	— two or more	4	154.50	4
F070	Os calcis — no reduction — rigid immobilization		68.70	
F071	— closed reduction		85.90	4
F072	— open reduction	4	171.70	4

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCOLOSKELETAL SYSTEM

Code	FOOT AND ANKLE - Cont'd	Asst.	Surg. $	Anaes.
	Phalanx — no reduction			
F056	— rigid immobilization — one		34.30	
E560	— each additional		6.90	
F058	— closed reduction — one		41.20	4
E561	— each additional		17.45	
F060	— open reduction	4	85.90	4
	Tarsus excluding os calcis			
F066	— no reduction — rigid immobilization		68.70	
F067	— closed reduction	3	85.90	4
F068	— open reduction	4	154.50	4
	Intra-articular fracture — I.P. joint			
F057	— closed reduction		54.95	
F059	— open reduction	3	103.00	4
	Reduction — Dislocations			
D035	Ankle — closed reduction		61.80	4
D036	— open reduction	4	137.40	4
R402	— recurrent	4	274.75	5
D027	Interphalangeal — closed		34.30	4
E578	— each additional		6.90	
D029	— open	4	85.90	4
D030	Metatarsophalangeal — closed		34.30	4
E579	— each additonal		6.90	
D032	— open	4	85.90	4
D033	Tarsus — closed		85.90	4
D034	— open	4	154.50	4

SURGICAL PROCEDURES

OPERATIONS ON THE RESPIRATORY SYSTEM

		Asst.	Surg.	Anaes.
Code	**NOSE**		**$**	
Z298	E.U.G.A. of nasopharynx (I.O.P.) — if only procedure performed		28.60	4
Z297	Insertion of prosthesis for nasal septal perforation (I.O.P.)		12.50	
	Endoscopy			
Z296	Fibreoptic endoscopy of upper airway (nasopharynx, hypopharynx or larynx) (I.O.P.) — if only procedure performed		10.70	
	Incision (I.O.P.)			
Z301	Drainage of abscess or haematoma of septum		25.00	4
Z302	**Turbinate reduction — uni or bilateral (to include cautery, cryosurgery, turbinectomy)**		39.35	4
	Excision			
Z304	Nasal polyp (I.O.P.) — single		14.30	
Z305	— multiple **or involving general anaesthetic** (unilateral)		39.35	4
Z308	— Choanal **polypectomy (I.O.P.) — unilateral**		39.35	4
Z309	**Biopsy (I.O.P.) — single**		12.50	
Z310	**— Multiple or involving general anaesthetic**		35.80	4
Z311	**Removal of foreign body I.O.P. — simple**		7.15	
Z312	**— complicated, or involving general anaesthetic**		35.80	
M010	**Excision of intranasal dermoid**	4	339.90	7
M011	**Excision of other intranasal lesions**	I.C.	I.C.	I.C.
	Reconstruction			
Note:	All procedures (including I.O.P.) connected with S.M.R. such as nasal polypectomy, turbinectomy, ethmoidectomy, etc. — add 50% of the listed benefit(s) for the other procedure(s).			
M012	**Septoplasty**		168.10	4
M013	Partial septorhinoplasty (excluding osteotomies)		254.00	7
M014	Septorhinoplasty		339.90	7
M019	— with autologous bone or cartilage graft		536.60	7
M024	— with non autologous graft or implant		429.30	7
R319	Graft **to nose** — autologous, bone or cartilage **(without septorhinoplasty)**	4	254.00	4
R320	— non-autologous **or** — prosthetic implant **(without septorhinoplasty)**	4	164.60	4
Note:	M013, M014, M019, **M024**, R319, R320 — claims for these procedures require O.H.I.P. authorization. (See Surgical Preamble, paragraph (17)).			
M015	Septodermoplasty (**to include fascial and other grafts**		214.65	4
M016	**Repair** of septal perforation		214.65	4

SURGICAL PROCEDURES

OPERATIONS ON THE RESPIRATORY SYSTEM

Code	**NOSE - Cont'd**	Asst.	Surg. $	Anaes.
M017	Localization of cerebrospinal rhinorrhea (fluorescein injection)		59.00	4
M018	**Endonasal augmentation** for atrophic rhinitis — unilateral **(including obtaining graft or preparing implant)**		214.65	4
M020	**Repair** of choanal atresia — uni or bilateral	4	254.00	4
M021	Puncture and insertion of tube **for choanal atresia — uni or bilateral**		64.40	4
M028	**Dilation of** choanal atresia — uni or bilateral		28.60	4
	Rhinoplasty for reconstruction of cleft lip — nasal deformity (not to be billed with repair of cleft lip)			
M030	**— complex, to include necessary grafts and septoplasty**	4	429.30	7
M031	**— tip and septum reconstruction only**		178.90	4
	Treatment of Epistaxis (Nasal Haemorrhage)			
Z314	Cauterization (I.O.P.) — unilateral		7.90	4
Z315	Anterior packing (I.O.P.) — unilateral		8.60	4
Z316	Posterior packing (I.O.P.) — **uni- or** bilateral		25.00	4
M027	Ligation of external carotid artery — **unilateral**	6	107.30	6

ACCESSORY NASAL SINUSES

Code	Description	Asst.	Surg.	Anaes.
	Antrum or sinus lavage (I.O.P.)			
Z317	Proetz displacement		3.90	
Z319	**Antral puncture and/or lavage** — unilateral or bilateral		28.60	4
M054	Maxillary, intranasal **antrostomy** — unilateral	4	82.30	4
M055	**Maxillary**, Caldwell-Luc **(intranasal antrostomy included) — unilateral**	4	157.40	4
M056	Maxillectomy **partial or complete**	7	429.30	10
E947	**— with orbital exenteration, add**		214.65	
M057	Frontal trephine **or sinusotomy**		114.50	4
M058	Radical **frontal sinusectomy**		322.00	5
M063	**Frontal osteoplastic flap for sinus obliteration (to include reconstruction)**	7	536.60	10
M059	External frontal-ethmoidal **sinusectomy and/or reconstruction — unilateral**	4	322.00	6
M060	Intranasal **ethmoidectomy** — unilateral		103.70	4
M023	External **or transantral ethmoidectomy** — unilateral **(to include Caldwell-Luc with transantral approach)**	4	254.00	4
M061	**Trans-septal sphenoidotomy or sphenoid sinusectomy**		178.90	4
M064	**External transethmoidol sphenoidotomy or sphenoid sinusectomy**	7	429.30	10

SURGICAL PROCEDURES

OPERATIONS ON THE RESPIRATORY SYSTEM

Code	ACCESSORY NASAL SINUSES - Cont'd	Asst.	Surg. $	Anaes.
M062	Vidian neurectomy — uni**lateral**	4	322.00	4
M066	Closure of antral fistula — **minor**		42.90	4
M067	**—complex or involving general anaesthetic (to include** Caldwell-Luc **if necessary)**		243.30	5
	LARYNX			
	Endoscopies (I.O.P.)			
Note:	When laryngoscopy and bronchoscopy or oesophago-bronchoscopy are carried out as combined procedures, the physician may claim for one or the other but not both.			
	Laryngoscopy			
Z321	Direct — with or without biopsy		42.90	6
Z322	— with removal of foreign body		75.10	6
Z323	— with removal of lesion(s)		103.70	6
Z343	— with dilation of larynx **to include** bronchoscopy **if necessary**		143.10	6
Z324	Indirect — with biopsy		23.25	6
Z325	— with simple removal of **foreign body**		23.25	6
E600	Using operating microscope — add to charges for laryngoscopy (i.e.: to Z321-Z323, Z327, Z328, Z330, Z342, Z343, Z348)		25.00	
	Introduction			
M080	**Teflon augmentation larynx**		128.80	6
	Excision (to include laryngoscopy)			
M081	Laryngectomy — total	6	500.85	13
M082	Laryngofissure	6	214.65	8
M084	**Laryngectomy — segmental, including reconstruction**	6	500.85	9
M085	Arytenoidectomy or **arytenoidopexy or lateralization procedure**	6	254.00	8
	Repair (to include laryngoscopy)			
M090	Laryngoplasty **e.g. repair of stenosis and fractures transections**		500.85	6
M089	Creation of tracheo-esophageal fistula	3	107.30	4
Z320	Insertion of voice prosthesis (I.O.P.)		17.90	
Z303	**Removal of laryngeal stent or keel**		71.55	4

SURGICAL PROCEDURES

OPERATIONS ON THE RESPIRATORY SYSTEM

Code	TRACHEA AND BRONCHI	Asst.	Surg.	Anaes.
	Endoscopy (I.O.P.)		$	
Notes:	(1) When laryngoscopy and bronchoscopy **or oesophago-bronchoscopy** are carried out as combined procedures, the physician may claim for one **procedure only.** (2) No claim should be made for bronchoscopy carried out immediately following thoracic surgery under the same anaesthetic by the same surgeon.			
	Bronchoscopy			
Z327	— with or without bronchial biopsy, suction or injection of contrast material		78.70	6
Z328	— with removal of foreign body		125.20	6
Z350	— with dilatation of stricture		110.90	6
Z351	— with selective endobronchial blocker or catheter insertion		110.90	6
Z352	— with palliative endobronchial tumour resection including laser or cryotherapy		125.20	6
Z342	— all 18 segmental with multiple concomitant random bronchial biopsies or brushings labelled as to site		125.20	6
Z349	**— with transbronchial lung biopsy under image intensification only**		114.50	**6**
E622	**— any bronchoscopic procedure for patients under 2 years of age, add**		53.70	
Z355	**Quadroscopy or panendoscopy — with or without biopsy (nasopharyngoscopy), laryngoscopy, bronchoscopy, oesphogoscopy) using separate instruments in search of malignant disease**		**125.20**	**6**
	Tracheo-bronchial aspiration (I.O.P.)			
Z344	First procedure		25.00	
Z345	Subsequent procedures performed by same physician (Not to apply to operating surgeons, when respiratory unit benefits apply, or within the first two hours post-operatively.)		12.50	
Z326	Change of tracheostomy tube		7.70	
Z346	Transtracheal aspiration		15.00	
Z356	**Closure of persistent tracheostoma**		89.40	
	Incision (I.O.P.)			
Z741	Tracheostomy	3	101.60	5
Z738	Insertion of Montgomery "T" Tube — for tracheal or laryngo-tracheal stricture (including bronchoscopy and dilatation)	4	139.50	8

SURGICAL PROCEDURES

OPERATIONS ON THE RESPIRATORY SYSTEM

Code	TRACHEA AND BRONCHI – Cont'd	Asst.	Surg. $	Anaes.
	Excision			
M102	Resection of cervical trachea **with cricoid resection**	9	547.35	10
M103	Segmental resection of trachea with either sternotomy or thoracotomy	9	851.40	13
M104	Carinal resection (without pulmonary resection)	11	1073.25	15
E623	**Re-operation after 30 days, add**		271.90	
	Repair			
M100	Tracheal rupture, transcervical	9	432.90	10
M101	Tracheal-bronchial rupture, transthoracic	9	568.80	13
	CHEST WALL AND MEDIASTINUM			
	Excision			
M105	Chest wall tumour resection of 2 or 3 ribs or cartilages with reconstruction of chest wall	9	339.90	13
E601	— for each additional rib (more than 3) to a maximum of 3 additional, add		37.60	
E602	— with sternal resection, add		114.50	
M107	Total sternectomy with reconstruction	9	493.70	13
N284	Excision of first rib **and/or cervical rib to include scalenotomy when required**		267.90	6
M106	Mediastinal tumour	9	425.70	13
	Repair			
	Chest wall (see Preamble, Part B, paragraph 25)			
M109	pleura — closed		I.C.	5
M110	— open		I.C.	13
M116	Chest wall fixation for trauma	4	239.70	6
E604	— for fixation of each additional rib exceeding four ribs, add		37.60	2
M117	Sternal fixation for trauma	4	171.70	6
R352	**Pectus excavatum or carinatum repair (by reconstruction, not implant)**	6	454.30	11
	Surgical Collapse			
M111	Thoracoplasty — one stage	9	207.50	10
E605	— for each additional rib (more than 3) to a maximum of 3 additional, add		37.60	
Z742	Phrenicotomy (I.O.P.)	3	68.00	5
	Incision			
Z353	Incisional biopsy of chest wall tumour (I.O.P.)	3	60.80	4
Z354	Excisional biopsy of rib for tumour (I.O.P.)	4	91.20	6
Z357	Thoracic window creation **I.O.P.**	5	143.10	7
Z358	Thoracic window closure **I.O.P.**	4	71.55	6

SURGICAL PROCEDURES

OPERATIONS ON THE RESPIRATORY SYSTEM

Code	**CHEST WALL AND MEDIASTINUM - Cont'd**	Asst.	Surg. $	Anaes.
	Endoscopies (I.O.P.)			
Z329	Mediastinoscopy		125.20	6
Z330	with bronchoscopy		164.60	6
Z333	**—with transbronchial biopsy under image intensification (including bronchoscopy)**		182.45	6
Z348	with bronchoscopy and mediastinotomy		232.50	6
Z347	Anterior mediastinotomy — when sole procedure performed	3	132.40	6
	LUNGS AND PLEURA			
	Introduction — Thoracentesis (I.O.P.)			
Z331	Aspiration for diagnostic sample		16.45	
Z332	Aspiration with therapeutic drainage with or without diagnostic sample		30.05	4
E606	Administration of chemotherapy **or sclerosing agent,** add		7.15	
Z334	Total Unilateral lung lavage with or without bronchoscopy using double lumen tube and single lung anaesthesia		193.20	3
	Endoscopy (I.O.P.)			
Z335	Thoracoscopy or pleuroscopy, with or without pleural biopsy, suction etc		71.55	5
	Incision			
Z340	Biopsy of lung, needle (I.O.P.)		50.10	4
Z336	Biopsy of pleura, needle (I.O.P.) — **including diagnostic aspiration**		29.30	4
Z341	Closed drainage — effusion or pneumothorax (I.O.P.)		41.50	4
E606	**— with administration of chemotherapy or sclerosing agent, add**		7.15	
Z337	Rib resection for drainage (I.O.P.)	6	83.35	6
M133	Thoracotomy for removal of foreign body	9	257.60	13
M137	Thoracotomy with or without biopsy	9	257.60	13
M134	Thoracotomy for post-operative haemorrhage or empyema	9	257.60	13
M132	Thoracotomy with repair of ruptured diaphragm	9	332.70	13
M130	Closure of broncho-pleural fistula (transthoracic or trans-sternal)	9	361.30	13
E609	— with intercostal muscle bundle, add		83.35	
E610	— with myovascular flap (pectoralis major, latissimus dorsi, rectus abdominis, add		178.90	
M135	Major decortation of lung for empyema or tumour	11	361.30	15
Z339	Intercostal drainage with insufflation of sclerosing agent under general anaesthesia (I.O.P.)	4	125.20	6

SURGICAL PROCEDURES

OPERATIONS ON THE RESPIRATORY SYSTEM

Code	**LUNGS AND PLEURA - Cont'd**	Asst.	Surg. $	Anaes.
	Excision			
Z338	Biopsy of pleura or lung — **with** limited thoracotomy (I.O.P.)	9	135.90	13
M138	Hilar lymphnode or lung biopsy with full thoracotomy	9	271.90	13
M142	Pneumonectomy — **with or without radical mediastinal node dissection or pericardial resection requiring repair**	10	629.60	14
E612	— total extra-pleural pneumonectomy, add		78.70	
E613	— sleeve pneumonectomy, add		164.60	
E614	— omental graft, add		110.90	
E615	— intra-pericardial dissection, add		53.70	
M143	Lobectomy **with or without radical mediastinal node dissection**	10	629.60	13
E616	— bi-lobectomy on right side, add		93.00	
E617	— with pleural tent, add		53.70	
E618	— with decortication of remaining lobe(s)		78.70	2
E619	— sleeve lobectomy, add		110.90	
E620	— with wedge bronchoplasty, add		53.70	
E621	— with diagnostic wedge resection, add		26.80	
E624	**— with completion pneumonectomy for positive resection margin, add**		71.55	
E625	**— with sleeve resection of pulmonary artery, add**		93.00	
M144	Segmental resection, including segmental bronchus and artery	10	629.60	13
M145	Wedge resection of lung	10	293.35	13
E608	— each additional (to a maximum of three)		41.85	
M151	Bullectomy for major bullous disease	10	418.60	13
M149	Pleurectomy, and/or apical bullectomy for pneumothorax	10	293.35	13
E607	Re-operation, (more than 30 days subsequent to previous excision) add to appropriate excision benefit		103.70	

SURGICAL PROCEDURES

OPERATIONS ON THE CARDIOVASCULAR SYSTEM

Code		Asst.	Surg.	Anaes.
			$	
R700	(a) with hypothermia and without bypass — **basic fee for cardiovascular procedures**			25
Note:	This code REPLACES PROCEDURAL BASIC code when hypothermia is used where basic is less than 25 units.			
E650	(b) pump bypass — **extra to surgeon's fee** (bypass includes cannulating and decannulating heart or major vein, major artery, supervision of pump and pump run.) (anaesthetist see Preamble, part B, paragraph 36(i))		243.30	28
Z743	(c) circulatory assist device e.g. intra-aortic balloon (includes cannulation, post operative daily care and supervision) (I.O.P.) — **open**		196.80	5
Z780	**circulatory assist device — percutaneous**		143.10	5
Z744	(d) decannulation of circulatory assist device (I.O.P.) — **open**		78.70	5
Z781	**decannulation — percutaneous**		25.00	
Z751	(e) repositioning of intra-aortic balloon pump (no claim to be made for repositioning within 24 hours of original insertion) (**I.O.P.**) — **open**		82.30	5
Z782	**repositioning — percutaneous**		53.70	
E655	(f) re-operation for failed vascular grafts — for repair or replacement of existing prosthesis (more than one month after original operation) add to appropriate benefit		114.50	
Z759	(g) Removal of failed vascular graft — **without arterial reconstruction** (I.O.P.) — **when sole procedure**		125.20	6
E658	(h) re-operation involving open heart procedures with pump (more than one month after initial operation) add to appropriate benefit		150.25	
	(i) Preliminary diagnostic catherization — extra to operative benefits. (see Diagnostic and Therapeutic Procedures)			
	(j) The basic anaesthetic benefit of 28 units for major cardiovascular surgery includes such procedures as C.V.P. line (G268), arterial line, blood **sampling,** blood **analysis and interpretations.**			

HEART AND PERICARDIUM

Note:	The benefit for gas endarterectomy of a coronary artery is the same as for coronary endarterectomy.			
	Cardiac massage			
	— closed (see Resuscitation on page 92.)			
R765	— open	13	143.10	13

SURGICAL PROCEDURES

OPERATIONS ON THE CARDIOVASCULAR SYSTEM

Code	HEART AND PERICARDIUM – Cont'd	Asst.	Surg.	Anaes.
			$	
R752	Atrio-ventricular sequential pacemaker with permanent atrial and ventricular endocardial electrodes	4	300.50	5
R751	Implantation of epicardial electrode(s) plus implantation of pack	6	307.70	20
Z411	Replacement of pack (I.O.P.)	3	93.00	5
Z412	Replacement or repair of pacemaker lead (I.O.P.)	3	68.00	5
M137	Thoracotomy — with or without biopsy	9	257.60	13
M134	— for post-operative hemorrhage	9	257.60	13
Z401	Aspiration of pericardium (I.O.P.)		46.50	
R750	Open biopsy of pericardium and drainage (transthoracic or epigastric)	13	207.50	13
R748	Pericardiectomy — one side open	13	422.10	20
R749	— both sides open or sternal split	13	669.00	20
R712	Cardiotomy with exploration	18	343.40	20
R713	— with removal of foreign body	18	422.10	20
R714	— with removal of tumour	18	343.40	20
	— electrophysiologic mapping of heart			
E660	— epicardial add		85.90	
E661	— endocardial and/or HIS Bundle add		117.70	
E662	— division of accessory conduction pathways add		42.90	
R920	Excision — ventricular tumour	18	447.20	28
R746	— ventricular aneurysm	18	601.00	28
R747	— aneurysm of sinus of Valsalva	18	543.80	28
R741	Coronary — endarterectomy	18	490.10	20
E651	— when done in conjunction with coronary artery repair add		132.40	
R742	Coronary artery repair — one	18	618.90	20
R743	— two	18	840.70	20
E654	— each additional		132.40	
	Implantation of internal mammary			
E652	— done in conjunction with coronary artery repair add		128.80	
R739	— sole procedure — single	18	486.50	20
R740	— double	18	601.00	20
	Ligation or division patent ductus			
R754	— infant or child	13	343.40	20
R755	— adolescent or adult	13	508.00	20
	Interruption of bronchial collateral arteries (one or more arteries)			
R857	— sole procedure	13	508.00	20
E663	— when done in conjunction with other cardiac surgery add		121.60	
R757	Resection coarctation — infant	13	440.00	20

SURGICAL PROCEDURES

OPERATIONS ON THE CARDIOVASCULAR SYSTEM

Code	HEART AND PERICARDIUM - Cont'd	Asst.	Surg.	Anaes.
			$	
R756	— child	13	422.10	20
R758	— adolescent or adult	13	558.10	20
R759	Congenital heart procedures — e.g. Blalock, Glenn, Potts, Waterston or Central	13	422.10	20
R763	Creation of ASD — by balloon septostomy	9	207.50	9
R762	— by thoracotomy or Sterling Edwards	18	422.10	20
R715	Closure atrial septal defect: secundum	18	422.10	20
R716	— endocardial cushion and valve defect	18	651.10	20
R717	— with anomalous pulmonary venous drainage	18	550.90	28
R718	Closure of ventricular septal defect	18	550.90	28
	Repair			
	Total repair Tetralogy of Fallot			
R720	— with or without previous arterial shunt	18	733.40	28
R722	Total anomalous pulmonary venous drainage	18	651.10	28
R723	Total correction transposition of great vessels	18	651.10	28
R721	Arterial repair of transposition	18	976.65	28
R921	Complete A-V canal	18	858.60	28
R922	Single ventricle	18	976.65	28
R923	Double outlet — right/left ventricle	18	858.60	28
R924	Double outlet ventricle with transposition	18	976.65	28
R925	Truncus arteriosus	18	976.65	28
R926	Interrupted aortic arch	18	858.60	28
R927	Aorto-pulmonary window	18	550.90	28
R928	R-V outflow tract with valve and tubular graft	18	615.30	28
R929	Debanding arterioplasty of pulmonary artery	18	547.35	28
R768	Pulmonary artery banding	13	343.40	20
R769	— with pressure studies by anaesthetist, extra/hour			5
R770	Correction of cor triatriatum	18	483.00	20
R771	Vascular ring	18	422.10	20
	VALVES			
R724	Pulmonary valvotomy	18	422.10	28
R725	Pulmonary valvotomy and infundibular resection	18	483.00	28
R772	Pulmonary valve replacement	18	483.00	28
R726	Tricuspid valvotomy	18	450.80	20
R727	Tricuspid annuloplasty	18	422.10	20
R728	Tricuspid valve replacement	18	483.00	28
R729	Mitral valvotomy	18	457.90	20
R730	Mitral valvotomy — restenosis	18	525.90	20
R734	Mitral annuloplasty	18	615.30	20
R735	Mitral replacement	18	615.30	28
R930	Aortic valvoloplasty	18	554.50	28
R736	Aortic valvotomy	18	450.80	20

SURGICAL PROCEDURES

OPERATIONS ON THE CARDIOVASCULAR SYSTEM

Code		Asst.	Surg.	Anaes.
	VALVES - Cont'd		$	
R737	Aortic infundibular resection (ventriculomyotomy)	18	572.40	28
R738	Aortic valve replacement	18	665.40	28
R863	Replacement of aortic valve, replacement of ascending aorta and re-implantation of coronary arteries (modified Bentall procedure)	18	1409.50	28
Note:	Multivalvular replacement — (R728, R735, R738, R772) — the benefit will be that for the major valve replaced plus 85% of the benefit for the additional valve or valves.			
	ARTERIES			
	Cannulation for infusion chemotherapy			
R775	— superficial temporal artery	3	61.90	4
R776	— hepatic artery	6	139.50	6
R778	— carotid	5	93.00	5
E696	— with pump by-pass, add		243.30	
R782	Gas embolization of peripheral arteries — complete care		27.50	
R760	Regional isolation perfusion **e.g.** iliac	10	268.30	10
R764	Exploration of major artery	6	178.90	I.C.
	Incision			
Z402	Arteriotomy (I.O.P.)		75.10	4
Note:	Not allowed in addition to other major cardiovascular surgery when performed at same time.			
	Repair — traumatic			
R790	suture of lacerated major artery	4	207.50	4
R795	**Repair of lacerated major artery** (including patch angioplasty)	10	325.55	10
R862	— by interposition graft or bypass graft	10	432.90	10
	Ligation			
R781	Ligation of artery **(as sole procedure)** — by region etc.*	3	68.00	I.C.*
R788	— internal maxillary artery (Caldwell Luc approach)	7	268.30	10
R789	— anterior ethmoid artery	6	100.20	6
R708	— internal iliac artery (uni or bilateral)	7	268.30	10
	Excision and/or Repair:			
Notes:	(1) Repair of artery implies either endarterectomy and/or by-pass graft: (2) The benefits listed for by-pass grafts include endarterectomy and/or thrombectomy of the artery being repaired **(3) The benefit for gas endarterectomy of coronary artery should be the same fee as for coronary endarterectomy**			

SURGICAL PROCEDURES

OPERATIONS ON THE CARDIOVASCULAR SYSTEM

Code	ARTERIES - Cont'd	Asst.	Surg. $	Anaes.
Note:	For excision of glomus tumour see Z811 (page 217).			
R815	Arterioplasty with or without patch graft (other than listed below)	10	343.40	10
R792	Carotid — endarterectomy	10	501.40	10
R796	— carotid body tumour	10	501.40	10
R798	— aneurysm — reconstruction or excision with graft	10	536.60	10
	Aortic arch reconstruction			
R830	— Innominate	10	565.20	10
R831	— Subclavian	10	565.20	10
R832	— Vertebral	10	565.20	10
E659	— with thoracotomy, add	3	109.10	7
	Thoracic aorta aneurysm — repair or excision with graft			
R799	— ascending	10	951.60	20
R800	— arch	10	1184.15	20
R801	— descending, with or without temporary shunt	10	826.40	20
R802	Abdominal aorta — aneurysm	10	787.05	17
R816	— plus unilateral common femoral repair	10	858.60	17
R817	— plus bilateral common femoral repair	10	930.15	17
E626	— plus implantation of inferior mesenteric artery, **add**		114.50	
E627	— ruptured, **add**		157.40	
E628	— ruptured plus unilateral common femoral repair, **add**	10	157.40	17
E629	— ruptured plus bilateral common femoral repair, **add**	10	157.40	17
	Mesenteric or celiac artery repair			
R811	— aneurysm	10	268.30	10
R935	— removal of band only	10	268.30	10
Note:	Use R935 for excision of coeliac ganglion.			
R936	— endarterectomy or graft	10	565.20	10
	Aorto-Iliac repair			
R783	— including common iliac repair (uni- or bilateral)	10	658.30	17
R784	— plus unilateral common femoral repair	10	776.30	17
R785	— plus bilateral common femoral repair	10	865.75	17
R814	— embolectomy or thrombectomy of bifurcation (**aorta** or graft)	10	300.50	10
R858	— total removal of infected aortic graft (stem and limbs) (arterial reconstruction extra)	10	601.00	17
E664	— with closure of duodenum, add		82.30	

SURGICAL PROCEDURES

OPERATIONS ON THE CARDIOVASCULAR SYSTEM

Code	ARTERIES - Cont'd	Asst.	Surg. $	Anaes.
R859	— partial removal of infected aortic graft (one limb only) (arterial reconstruction extra)	10	225.40	10
R806	Renal artery repair	10	565.20	10
R805	Renal artery — aneurysm — reconstruction or excision with graft	10	565.20	10
R807	Splenic artery aneurysm — reconstruction or excision with graft	10	268.30	10
R786	Iliac repair (to include internal iliac aneurysm)	10	525.90	10
R937	Ilio-femoral bypass graft	10	525.90	10
	Per-obturator ilio-femoral graft			
R860	— with saphenous vein	10	586.70	10
R861	— with prosthetic graft	10	572.40	10
R855	Common femoral/profunda femoris repair (when sole procedure performed)	10	364.90	10
R856	Extended profundoplasty (profunda femoris)	10	511.60	10
Notes:	(1) Common femoral artery repair (eg. R784, R785) includes repair to the profunda femoris artery as far as the first major branch. (2) If the repair extends beyond the first major branch of the profunda femoris artery, R815 may be claimed in addition. (3) If the repair extends beyond the second major branch of the profunda femoris artery, R856 instead of R815 may be claimed in addition.			
R933	Axillo-femoral, femoro-femoral, or axillo-axillary graft	10	429.30	10
R934	Aorto-femoral unilateral graft	10	565.20	17
R808	Femoral aneurysm — reconstruction or excision with graft	10	393.50	10
R864	Repair of false aneurysm at groin anastomosis	10	583.10	10
R809	Femoral — popliteal endarterectomy	10	497.30	10
	Femoral — popliteal **or cross** bypass graft with or without endarterectomy			
R791	— with saphenous vein	10	550.90	10
R794	— with prosthetic graft	10	493.70	10
	Femoro-anti/post. tibial/peroneal bypass graft with or without endarterectomy			
R787	— with saphenous vein	10	654.70	10
R780	— with prosthetic graft	10	572.40	10
R810	Popliteal aneurysm	7	525.90	10
	Peripheral arteries other than listed			
R812	— aneurysm	7	268.30	10
R813	Embolectomy — artery or graft	7	211.10	10
R867	**Thrombectomy — artery or graft**	**7**	196.80	**10**
E649	**— when done in conjunction with other vascular repairs, add**		71.55	
R866	**Gastric devascularization — when sole procedure**	**10**	357.75	**10**

SURGICAL PROCEDURES

OPERATIONS ON THE CARDIOVASCULAR SYSTEM

Code	**VEINS**	Asst.	Surg. $	Anaes.
R827	Creation of A V fistula	4	232.50	6
R848	Erasure and coagulation	3	68.00	4
	Excision			
	Resection of A V aneurysm or fistula with or without major graft			
R825	— major aneurysm by region*	10	640.40	I.C.*
R826	— minor aneurysm etc.	10	318.40	I.C.
E696	— with pump by-pass, add		243.30	
R847	Stasis ulcer and skin graft — per leg	3	139.50	5
R845	Stasis ulcer, multiple ligation and skin graft — per leg	5	236.10	5
	Ligation			
Z745	Saphenous (IOP)		34.00	4
Z746	Femoral (IOP)	3	49.00	4
Z747	Popliteal (IOP)	3	49.00	4
Z748	Internal jugular (IOP)	5	97.70	5
R839	Internal iliac	6	257.60	10
R834	I.V.C. — transabdominal	6	289.80	10
R838	— transvenous	6	196.80	10
Note:	Use R838 for insertion Mobin Uddin Umbrella Filter.			
	Ligation, Avulsion, Electrocoagulation			
R837	Multiple	4	101.60	4
E656	— plus stripping, add		68.00	1
R844	And/or stripping — recurrent varicose veins	5	239.70	5
R842	Extra fascial and sub-fascial incompetent perforators by full fascial technique	5	246.80	6
E653	plus stripping add		82.30	
	Repair			
R820	Lacerated major vein	4	139.50	4
R835	SVC bypass graft	7	497.30	17
E696	— with pump by-pass, add		243.30	
R836	Pulmonary embolectomy	18	565.20	20
R828	Ilio-femoral thrombectomy with or without femoral vein ligation	10	289.80	10
E657	plus I.V.C. ligation, add		289.80	
R829	Thrombectomy other than above (see Preamble, Part B, paragraph 25)	I.C.	I.C.	I.C.
R865	Distal spleno-renal shunt	10	826.40	10
	Anastomosis			
R822	Porto-caval	10	601.00	10
R823	Spleno-renal — abdominal approach	10	733.40	10
R821	— transthoracic approach	10	733.40	13
R824	Meso-caval	10	565.20	10

SURGICAL PROCEDURES

OPERATIONS ON THE HAEMIC AND LYMPHATIC SYSTEMS

Code	SPLEEN AND MARROW	Asst.	Surg. $	Anaes.
	Incision (I.O.P.)			
Z404	Splenic puncture and aspiration		53.70	4
Z403	Bone marrow aspiration		22.90	
Z408	Bone marrow core biopsy (with biopsy needle)		41.30	4
Note:	(1) Z408 may not be allowed with Z403 (Not the same as Z403.) (2) Bone marrow interpretation — see L802 Laboratory Medicine Schedule			
Z430	Bone marrow transplantation (aspiration from donor and infusion into recipient) — team benefit (I.O.P.)	7	375.60	8
Note:	Z430 — bone marrow transplantation is not a benefit of OHIP for treatment of some conditions. Please refer to OHIP District Office for qualifying diagnoses.			
	Excision			
R905	Splenectomy — partial or complete	7	318.40	7
	LYMPH CHANNELS			
	Excision			
R907	Cystic hygroma — unilateral	4	225.40	6
	Anastomosis			
R846	Micro lympholympho or lymphovenous anastomosis	7	450.80	7
	LYMPH NODES			
	Incision			
Z410	Drainage of sub-fascial abscess (I.O.P.)		49.00	4
	Excision			
R910	Neck — limited e.g. submandibular supra omohyoid	6	178.90	6
R911	— radical	6	397.10	8
R915	— modified radical including functional with preservation of spinal accessory nerve	6	450.80	8
R912	Ileoinguinal, radical resection	6	318.40	8
	Axillary or inguinal nodes			
R913	— radical resection	4	239.70	6
R914	— limited resection	4	128.80	4
	Biopsy I.O.P.			
Z405	— cervical, axillary, inguinal	4	41.30	4
Z406	— scalene	4	82.30	4

SURGICAL PROCEDURES

OPERATIONS ON THE HAEMIC AND LYMPHATIC SYSTEMS

Code	LYMPH NODES – Cont'd	Asst.	Surg. $	Anaes.
Z578	— multiple para-aortic lymph nodes	6	49.00	6
	— percutaneous retroperitoneal			
Z407	— one group	4	57.20	4
Z409	— two or more groups	4	85.90	4
R916	Re-exploration of vascular graft and closure of lymph fistula in groin	4	128.80	6

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM

Code		Asst.	Surg.	Anaes.
	ORAL CAVITY AND PHARYNX— to include nasopharynx, oropharynx, hypopharynx except where otherwise specified		$	
	Incision			
S001	Drainage of **oropharyngeal abscess**		64.40	5
Z524	**Drainage of lateral pharyngeal or deep neck abscess (external approach)**	3	107.30	4
Z506	Drainage of alveolar abscess, general anaesthetic (I.O.P.)		25.00	4
Z507	Palate abscess (I.O.P.)		25.00	4
Z501	Biopsy (I.O.P.)		25.00	
Z537	**—involving general anaesthetic**		53.70	4
	Tongue tie, release of — (I.O.P.)			
Z111	infant		10.70	
Z112	child or adolescent — local anaesthetic		10.70	
Z113	— general anaesthetic		35.80	4
S031	**Palatal Fenestration**		107.30	4
	Excision			
Z502	Excision of lesion (I.O.P.)—**less than 2 cms.**	3	35.80	4
S003	—2 to 4 cms.	4	150.25	6
S006	**—over 4 cms.**	4	250.40	6
S004	Excision of ranula	3	107.30	4
S005	Composite resection of primary tumour, e.g. mouth, tongue, tonsil or pharynx plus ipsilateral mandible	10	343.40	12
E705	— with ipsilateral neck dissection, add		168.10	
S050	Cryotherapy for treatment of premalignant or malignant lesion(s) of oral cavity or sinuses — minor — initial		60.80	4
S052	— intermediate		107.30	4
S054	— major		178.90	6
S018	Glossectomy — partial	6	128.80	8
S019	— complete	6	196.80	8
Z109	Wedge excision of lesion (I.O.P.)		42.90	4
S020	Glossoplasty	4	96.60	4
S023	Extraction of tooth (complete care) — single		13.40	4
E700	— each additional tooth		8.40	
S028	Dentigerous cyst	4	46.50	4
S900	Basic units for anaesthesia with any unlisted dental surgical procedure performed by a dental or oral surgeon (see also OHIP Bulletin #4069)			I.C.

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM

Code	ORAL CAVITY AND PHARYNX - Cont'd	Asst.	Surg. $	Anaes.
S021	Repair of extensive laceration (see Preamble, Part B, paragraph 25)	4	I.C.	I.C.
	Minor laceration — see Skin.			
Z509	Uvulectomy — partial or complete (I.O.P.)		17.20	4
S034	Cleft palate repair	6	243.30	8
S035	Removal of sutures under general anaesthesia		21.50	4
S032	Bone graft to palate	6	243.30	8
S030	Closure of fistula — anterior alveolar	4	114.50	4
S033	— palate	6	196.80	6
	Repair			
S069	Pharyngoplasty	8	243.30	8
S002	Excision of parapharyngeal space lesions (with mobilization of parotid gland if necessary)	4	429.30	8
S067	Pharyngectomy — trans-hyoid or lateral	8	429.30	11
S068	Pharyngo-laryngectomy	8	572.40	14
S058	Branchial — cyst	4	182.45	4
S059	— sinus	4	236.10	4
S060	— fistula	4	254.00	5
S061	Thyroglossal duct **remnant**	4	214.65	4
S062	— **repeat** procedure	4	286.20	4
S063	Tonsillectomy — Child or adult		100.20	4
	Tonsillectomy and Adenoidectomy — Same benefits as Tonsillectomy.			
S065	Adenoidectomy — Child or Adult		53.70	4
S066	Secondary suture or cauterization **72 hours after** T and A **or by a surgeon other than the operation surgeon any time post operatively** — when haemorrhage occurs after initial procedure and is treated surgically		35.80	4
	SALIVARY GLANDS AND DUCTS			
	Incision			
Z500	Sialolithotomy (I.O.P.)		21.50	
Z521	— involving general anaesthetic	3	71.55	4
	Excision			
S042	Sub**mandibular** gland	4	178.90	4
S043	Parotid gland — total (with preservation of facial nerve)	6	457.90	8
S044	— total (without preservation of facial nerve)	6	343.40	8
S045	— subtotal (with preservation of facial nerve)	6	393.50	7
S047	— repeat subtotal (with preservation of facial nerve)	6	457.90	7
S046	— subtotal (without preservation of facial nerve)	6	307.70	6

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM

Code	**SALIVARY GLANDS AND DUCTS – Cont'd**	Asst.	Surg. $	Anaes.
Z522	Excision small tumour (I.O.P.)	4	35.80	4
	Reconstruction			
S049	Plastic repair of duct	4	143.10	4
Z511	Dilation **and/or probing** of duct (I.O.P.)		21.50	4
S057	Submandibular duct relocation	6	254.00	6
	LIPS			
	Incision			
Z503	Biopsy (I.O.P.)		25.00	4
	Excision			
S011	Wedge resection of lip — vermilion	3	50.10	4
S010	Wedge resection of lip with plastic repair	3	168.10	4
Z504	Excision of lesion (I.O.P.)	3	42.90	4
S012	Lip shave — vermilionectomy	3	143.10	4
	Reconstruction			
S013	Hare lip — unilateral	6	243.30	8
S014	Reconstruction with lip switch flap	6	307.70	8
S015	Complex reconstruction or revision of previous repair and excision (see Preamble, Part B, paragraph 25)		I.C.	I.C.
	OESOPHAGUS			
Note:	For procedures on the Oesophagus, the following basic units for assistants and anaesthetists will apply except if a basic benefit is listed:			
S073	Cervical approach	6		7
S074	Thoracic approach	10		13
S075	Abdominal approach	7		8
	Endoscopies (I.O.P.)			
Z515	Oesophagoscopy, with or without biopsy		50.10	4
Z516	with removal of foreign body		82.30	4
Z517	Oesophagoscopy with injection of varices -- initial		89.40	4
Z518	— subsequent within 30 days		64.40	4
Z519	Oesophagoscopy with dilation		96.60	4
Z520	Oesophago-bronchoscopy with or without biopsy		93.00	6
Z567	Subsequent procedure (within three months following previous endoscopic procedure)		53.70	6
Z399	Oesophagoscopy-gastroscopy with or without duodenoscopy — elective		75.10	4
Z400	— for active bleeding		82.30	4

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM

Code	**OESOPHAGUS - Cont'd**	Asst.	Surg.	Anaes.
			$	
E701	— with laser coagulation **or diathermy**, add		22.50	
E698	**— with pneumatic dilation, add**		**71.55**	
Z568	Subsequent procedure (within three months following previous endoscopic procedure)		50.10	4
E702	— with multiple (3 or more) biopsies of specific lesion, add		10.70	
E703	— with snare polypectomy, add		35.80	
E799	— each additional polyp, add — (to a maximum of 2 additional polyps)		17.90	
	Incision			
	Oesophagostomy			
S084	Cervical — other than neonatal		135.90	
S085	— neonatal		207.50	
	Intrathoracic oesophagus tube			
S082	— via laparotomy		279.00	6
S083	— via oesophagoscope (includes Z515)		207.50	6
S081	Transoesophageal division of oesophageal varices		357.75	
S080	**Oesophageal — gastric devascularization (including splenectomy and oesophageal division/anastomosis**		590.30	
	Excision			
S087	Intrathoracic diverticulum		329.10	
S088	Crico pharyngeal myotomy		264.70	
E699	**— with diverticulum excision, add**		25.00	
S089	Partial oesophageal resection and reconstruction (including intestinal transposition)		701.20	17
S090	Total thoracic oesophageal resection		590.30	13
E730	with reconstruction, add		357.75	4
	Repair			
S161	**Oesophageal myotomy, partial (below aortic arch)**		386.40	
E758	— with oesophageal hiatus hernia repair; **add to S161**		143.10	
E699	**— with diverticulum excision, add**		25.00	
S100	Total thoracic oesophageal myotomy when sole procedure performed		490.10	
E758	— with oesophageal hiatus hernia repair, add to S100		143.10	
S091	Oesophageal hiatus hernia — abdominal or transthoracic approach with fundal plication		364.90	
S092	— recurrent		468.65	

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM

Code	OESOPHAGUS - Cont'd	Asst.	Surg.	Anaes.
			$	
E744	— with gastroplasty, add (to S091 or S092)		75.10	
E742	— When S091 or S092 with or without gastroplasty is done in conjunction with cholecystectomy and/or vagotomy with or without drainage procedures, add E742 (to S091, S092, with or without E744) for each additional procedure(s) performed		143.10	
S095	Oesophageal stricture (Thal) — may include oesophageal hiatus hernia repair with or without gastroplasty		422.10	
S096	Ruptured oesophagus, **suture and drainage**		329.10	
S097	Oesophago-gastrostomy **for by-pass (when sole procedure performed)**		350.60	
S098	Oesophageal bypass, abdomen **to neck — with stomach**		572.40	
S099	**—with colon or jejunum**		787.05	
	Suture			
S102	Closure of oesophago-tracheal fistula (includes oesophageal reconstruction and lengthening if necessary)		404.25	
	Dilation of Oesophagus (I.O.P.) — when sole procedure performed.			
Z529	Passive (bougie) — initial session		26.80	
Z530	— repeat session (within three months following previous dilation)		17.90	
Z525	Pneumatic		71.55	
Z523	With rigid dilators guided over a string or wire		35.80	
Z531	Repeat dilations during the same admission		17.90	
	STOMACH			
	Endoscopies (I.O.P.)			
Z527	Gastroscopy (with or without biopsy or photography)		50.10	4
Z547	Gastroscopy with removal of foreign body		68.00	4
Z528	Subsequent (within three months following previous gastroscopy)		42.90	4
	Incision			
S116	Gastrotomy — with removal of tumour or foreign body	6	196.80	7
E731	— with suture of bleeding peptic ulcer, add		53.70	2
S117	Pyloromyotomy (Ramstedt's)	5	200.30	10
S118	Gastrostomy	6	157.40	7
E697	**— with repair of Mallory Weis laceration, add**		93.00	

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM

Code		Asst.	Surg.	Anaes.
	STOMACH - Cont'd		$	
E707	— when done with another intra-abdominal procedure		41.50	
	Excision			
Z526	Biopsy — (Incisional) by gastrotomy (I.O.P.)		48.65	
Z533	— by intubation (I.O.P.)		23.25	
	Gastrectomy			
S122	Wedge resection for ulcer	7	225.40	7
E708	with vagotomy, add		53.70	
E713	with previous partial gastrectomy, add		89.40	
S123	Partial or subtotal — distal	7	411.40	8
S125	— proximal	7	450.80	8
E731	with suture of bleeding peptic ulcer, add		53.70	2
E708	with vagotomy, add		53.70	
E709	with cholecystectomy, add		68.00	
E706	with choledochotomy, add		78.70	
E711	after previous gastro-enterostomy, add		68.00	
E712	After previous vagotomy, and pyloroplasty, add		68.00	
E713	After previous partial gastrectomy, add		89.40	
S128	Total gastrectomy, with or without splenectomy	7	618.90	9
E709	**— with cholecystectomy, add**		68.00	
E706	**— with choledochotomy, add**		78.70	
S129	**Conversion of previous gastrectomy to Roux-en-y**	7	457.90	9
S131	Vagotomy — truncal or selective	7	239.70	7
S124	— highly selective (as sole procedure without pyloroplasty or gastroenterostomy)	7	314.80	7
S121	Transabdominal vagotomy after previous vagotomy	7	271.90	8
S120	Gastric bypass or partition, for morbid obesity	7	404.25	10
	Repair			
S132	Pyloroplasty	7	225.40	7
S133	Pyloroplasty and vagotomy	7	343.40	7
E731	— with suture of bleeding peptic ulcer, add		53.70	2
S137	Pyloroplasty or gastroenterostomy plus vagotomy and cholecystectomy	7	500.85	8
E721	— with choledochotomy, add		78.70	1
S134	Gastroduodenostomy or gastrojejunostomy	7	225.40	7
E716	— either of above plus vagotomy add		110.90	
E711	— after previous gastroenterostomy, add		68.00	
E721	— with choledochotomy, add		78.70	1
	Suture			
S138	Closure of gastrostomy or other external fistula of stomach	5	193.20	6
S139	Gastrorrhapy (for perforated ulcer or wound)	6	200.30	7

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM

		Asst.	Surg.	Anaes.
Code	**STOMACH - Cont'd**		$	
S140	Closure of gastrocolic fistula	7	375.60	7
	Introduction			
Z534	Gastric Cooling (I.O.P.) — ice water lavage of stomach		19.00	
Z532	Gastric Cooling (I.O.P.) — oesophagogastric balloon, with alcohol coolant continuously recirculated		63.00	4
	INTESTINES (EXCEPT RECTUM)			
	Endoscopies (I.O.P.)			
Z560	Duodenoscopy (not allowed if Z399 **and Z400** performed on same patient within three months)		64.40	4
Z561	— with cannulation of pancreatic and/or common bile duct (see also code Z558, page 185)		143.10	4
Z749	Subsequent procedure (within three months following previous endoscopic procedure)		50.10	4
Z555	Endoscopy — of sigmoid to descending colon		37.60	4
E740	— to splenic flexure, add		41.10	
E741	— to hepatic flexure, add		21.50	
E747	— to caecum, add		21.50	
E717	—if biopsy and/or coagulation of angiodysplastic lesion(s) (one or more), add		17.90	
E749	— when Z555 rendered in private office, add		11.40	
Note:	for sigmoidoscopy with rigid scope, see page 182			
Z570	Fulguration of polyp through colonoscope		30.80	4
E719	— each additional polyp, add — (maximum of 4 additional polyps)		15.40	
Z571	Excision of polyp through colonoscope		100.20	4
E720	— each additional polyp, add — (maximum of 2 additional polyps)		50.10	
	Incision			
	Enterotomy			
S149	Ileostomy	6	239.70	7
S150	Small intestine — including excision of polypi or biopsy	6	239.70	7
S151	Insertion of feeding enterostomy	6	193.20	7
E737	— when done with another intra-abdominal procedure add		48.65	
S154	Large intestine — including excision of polypi	6	239.70	7
S155	Colonoscopy with laparotomy	6	225.40	7
S156	Exteriorization of intestine (Mickulicz)	6	225.40	6
S157	Colostomy	6	239.70	6
S158	Caecostomy	6	178.90	6

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM

		Asst.	Surg.	Anaes.
Code	**INTESTINES (EXCEPT RECTUM) – Cont'd**		$	
S160	Entero-enterostomy	6	239.70	7
	Excision			
S162	Local excision of lesion of intestine	6	239.70	7
Z750	Resection of exteriorized intestine (I.O.P.)	6	48.65	6
	Resection with anastomosis			
	Small intestine			
S164	duodenum	6	357.75	7
S165	other	6	336.30	7
	Small and large intestine			
S166	terminal ileum, caecum and ascending colon	7	397.10	7
S167	Large intestine — any portion	7	397.10	7
E714	Repair of entero-cutaneous fistula in conjunction with bowel resection, add		45.10	
S168	Ileostomy, subtotal colectomy	7	543.80	7
S169	Total colectomy with ileo-rectal anastomosis	9	636.80	9
S171	Left hemicolectomy with anterior resection or proctosigmoidectomy (anastomosis below peritoneal reflection and mobilization of splenic flexure)	7	543.80	7
S172	Total colectomy with mucosal proctectomy with ileal pouch, ileoanal anastomosis and loop ileostomy	9	1126.90	10
S170	Ileostomy plus total colectomy plus abdomino-perineal resection	9	751.30	10
S173	2-Surgeon team — abdominal	9	636.80	10
S174	— perineal		186.00	
E738	— with continent ileostomy, add to S168, S169, S170, S173 *or* S174		250.40	
E718	Bowel resection following previous resection with anastomosis, or following S217, S213, S214 or S215, add		93.00	
Note:	E718 is not to be added to S181, S182, S185, **S191, S192, S193** or **S218.**			
S188	Bowel resection without anastomosis (colostomy and mucous fistula)	6	354.20	6
S189	Intestinal bypass for morbid obesity	7	393.50	10
	Intestinal Obstruction — one stage (if staged procedure, refer to Surgical Preamble, paragraph (3)).			
S175	Without resection	6	300.50	6
S176	With entero-enterostomy	6	375.60	7
S177	With resection	6	443.60	7
S180	With enterotomy	6	336.30	7
S178	Intestinal atresia (newborn)	6	443.60	7
S179	Meconium ileus	6	443.60	7

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM

Code	INTESTINES (EXCEPT RECTUM) - Cont'd	Asst.	Surg. $	Anaes.
	Repair			
	Revision of ileostomy or colostomy			
S181	— skin level	5	71.55	5
S182	— full thickness	6	225.40	6
S192	Simple revision of continent ileostomy pouch	6	225.40	6
S191	Complete reconstruction of continent ileostomy to include valve repair	6	618.90	7
S193	Revision of standard ileostomy into continent ileostomy pouch	6	497.30	7
S183	Caecopexy or sigmoidopexy when sole procedure performed	5	150.25	6
	Suture			
S184	Suture of intestine	6	203.90	6
E721	— with choledochotomy, add		78.70	1
	Closure of colostomy or enterostomy			
S185	— with or without resection and/or anastomosis	6	239.70	7
S187	Plication of small intestine for adhesions	6	343.40	7
Note:	For division or removal of adhesions only, use S312.			
	Manipulation (I.O.P.)			
Z538	Reduction of prolapse		16.45	4
Z539	Dilation of gastrostomy enterostomy, colostomy, etc.		16.45	4
Z540	Intubation of small intestine (therapeutic or diagnostic) with or without fluoroscopy		41.50	
E732	with biopsy, add		19.00	
	MECKEL'S DIVERTICULUM			
	Excision			
S194	Meckel's diverticulum	5	196.80	6
S159	**— with small bowel resection**		239.70	
	MESENTERY			
	Excision			
S195	Local excision of lesion	5	164.60	6
S199	Resection of mesentery	5	196.80	6
	APPENDIX			
	Incision			
S204	Drainage of abscess	5	153.80	6
	Excision			
S205	Appendectomy	5	164.60	6
S206	— with gross perforation and peritonitis	5	236.10	6

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM

Code	RECTUM	Asst.	Surg.	Anaes.
	Endoscopy (I.O.P.)		$	
Z535	Sigmoidoscopy (with rigid scope), with or without anoscopy		24.30	4
Z536	— with biopsy		29.00	4
Z592	— with decompression of volvulus **or reduction of obstructed Kock ileostomy**		32.20	4
E746	When Z535, Z536 or Z592 rendered in private office, add		3.75	
	Incision			
	Proctotomy			
S210	— with exploration	4	68.00	4
S211	—with decompression (imperforate anus)	4	68.00	4
S212	—with drainage (perirectal abscess)	4	68.00	4
	Excision			
	Proctectomy			
S213	Anterior resection or proctosigmoidectomy (anastomosis below peritoneal reflection)	8	504.40	8
S214	Abdomino-perineal resection or pull through	8	608.20	10
	Two surgeon team			
S215	abdominal surgeon	8	504.40	10
S216	perineal surgeon		178.90	
S217	Hartmann procedure	8	411.40	9
S218	Colon reconstruction following Hartmann procedure (includes E718)	8	504.40	8
Z752	Biopsy of rectosigmoid for Hirschsprung's disease (I.O.P.)	3	53.70	4
E710	—each additional biopsy (to a maximum of three additional)		19.00	
S222	Presacral or trans-sacral proctotomy and excision of lesion	4	225.40	6
Z572	Electrocoagulation and/or excision of rectal carcinoma (I.O.P.) — initial	3	93.00	4
Z573	— repeat	3	53.70	4
	Polyps or tumours of rectum or sigmoid (max. — 2 polyps any size or technique) (I.O.P.)			
Z753	— electrocoagulation — base under 2 cm		15.70	4
Z754	—excision — base under 2 cm	3	53.70	4
Z755	—electrocoagulation or excision base over 2 cm	3	93.00	4

Note: For fulguration or excision of tumours through the colonoscope use codes Z570, Z571.

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM

Code	RECTUM - Cont'd	Asst.	Surg. $	Anaes.
	Repair			
S223	Anastomosis of rectum	4	314.80	6
S224	Proctostomy	4	193.20	4
	Rectal prolapse			
S225	Excision of mucus membrane	3	153.80	4
S226	Perineal repair, major	4	239.70	4
S227	Abdominal approach	6	361.30	8
S228	Insertion of Thiersh wire	3	125.20	4
	Suture			
S229	Suture of rectum, trauma — external approach	4	153.80	4
	Closure of fistula			
S231	Recto vaginal (any repair)	4	225.40	6
S525	Recto vesical	5	289.80	6
	Manipulation (I.O.P.)			
Z541	Dilation, and/or disimpaction or removal of foreign body under general anesthetic (when sole procedure performed)		37.60	4
Z756	Fecal disimpaction — no anaesthetic		24.30	
	OPERATIONS ON THE ANUS			
Note:	The benefits for excision, ligation, injection of haemorrhoids and treatment of intra or perianal condyloma accuminata include anoscopy.			
	Endoscopy			
Z543	Anoscopy (proctoscopy) (I.O.P.)		4.10	
	Incision			
Z544	Biopsy (I.O.P.		22.50	4
Z545	Thrombosed haemorrhoid(s) (I.O.P.)		16.45	4
S241	Sphincterotomy	3	57.20	4
S242	— with excision of fissure	3	107.30	4
	Excision			
S246	Excision of fissure	3	75.10	4
S247	Haemorrhoidectomy with or without sigmoidoscopy or repair of fissure and/or sphincterotomy and/or anal dilahen	3	150.25	4
Note:	Includes dilation/injection of anal sphincter and removal of anal polyp.			
Z565	Complete haemorrhoidectomy using cryotherapy and/or Barron ligation(s) including rectal dilation (I.O.P)		61.90	4

Code	OPERATIONS ON THE ANUS – Cont'd	Asst.	Surg. $	Anaes.
Z546	Barron ligation(s) (I.O.P.) (not to exceed 6 in any one year)		17.90	
Z566	Barron ligation(s) plus cryotherapy (I.O.P.) (not to exceed 6 in any one year)		22.50	
S249	Local excision for malignancy	3	100.20	4
Z757	Excision of benign anal lesion(s) (I.O.P.)	3	26.50	4
S251	Fistula-in-ano	3	150.25	4
	Introduction (I.O.P.)			
Z575	Haemorrhoid injections (Maximum 6 in any one year)		17.90	
Z576	Injections for anal fissure		23.25	4
	Repair			
S253	**Low imperforate anus repair**	7	293.35	7
S260	**High imperforate anus repair (supra/levator)**	7	608.20	7
S256	Excision of scar, for stenosis	3	85.90	4
S257	Anoplasty, for stenosis	4	193.20	4
S258	Repair of anal sphincter	4	193.20	4
S259	Repair of anal sphincter and ano-rectal ring	4	232.50	4
	Destruction (I.O.P.)			
Z548	Cauterization of fissure		22.50	4
	Fulguration of condylomata			
Z549	— local anaesthetic		20.70	
Z758	— general anaesthetic	3	48.65	4
	Manipulation			
Z550	Dilation of anal sphincter (I.O.P.)		7.50	4
S248	Peter Lord procedure (includes sigmoidoscopy and dilation of anus)		32.20	4
	LIVER			
	Incision (I.O.P.)			
Z554	Biopsy, incisional		46.50	
Z551	Biopsy, needle		44.40	4
	Excision			
	Hepatectomy			
S269	Local excision of lesion	7	225.40	7
S275	Partial lobectomy	8	382.80	8
S270	Left lateral segmental excision (through falciform ligament)	12	590.30	12
S267	Complete left or right lobectomy	12	858.60	12
S271	Extended right lobectomy (through falciform ligament)	12	858.60	12

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM

Code	LIVER – Cont'd	Asst.	Surg. $	Anaes.
S272	Laparotomy, cholangiogram and biopsy (neonatal jaundice)	6	239.70	6
	Repair			
S273	Marsupialization and/or decompression of cyst(s) or abscess(es)	7	225.40	7
E715	—more than three cysts or abscesses, add		48.65	

BILIARY TRACT

Notes:
(1) When the common bile duct is examined during abdominal surgery, no additional benefit over and above the surgical benefit may be claimed for choledochoscopy or for cholangiogram.
(2) Biliary tract endoscopy includes examination of stomach and duodenum (i.e. Z558 or Z559 may not be claimed with Z560 or Z561).
(3) No claim should be made for cholecystectomy with hepatic lobectomy (S271, S267).

Code	Description	Asst.	Surg. $	Anaes.
Z558	Manipulation and/or removal of common bile duct stones with or without sphincterotomy (see also code Z561, page 179)		196.80	5
Z559	Subsequent procedure (within three months following previous endoscopic procedure)		89.40	5
Z556	**Insertion of endobiliary prosthesis — first one**		53.70	
Z557	**— each additional (max. of 3)**		28.60	
Z593	**Nasobiliary catheter insertion**		35.80	
	Drainage			
S233	Percutaneous transhepatic catheter drainage of obstructed bile ducts, including daily supervision and including percutaneous cholangiogram and catheterization to duodenum if achieved		171.70	
S234	— replacement of catheter in above		34.00	
Z542	Intubation of bile duct for obstruction (I.O.P.)		45.10	
Z562	Biliary duct calculus manipulation and/or removal via T-tube tract (I.O.P.) — when sole procedure performed		75.10	7
	Incision			
S278	Cholecystostomy	7	243.30	7
S276	Choledochotomy	7	411.40	8
E704	— with choledochoscopy, add		18.60	
S280	Transduodenal sphincterotomy and choledochotomy	7	579.55	9
S281	Choledochoduodenostomy or choledochoenterostomy or choledochocholedochostomy	7	486.50	9

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM

Code		Asst.	Surg.	Anaes.
	BILIARY TRACT - Cont'd		$	
S282	Cholecystogastrostomy	7	293.35	7
S283	Cholecystoenterostomy	7	293.35	7
E743	— with enteroenterostomy, add (to S281, S283)		100.20	
S285	Intrahepatic choledochoenterostomy (anastomosis above the common duct bifurcation)	9	601.00	12
	Excision			
S287	Cholecystectomy	7	307.70	7
E721	— with choledochotomy, add		78.70	1
E722	— with transduodenal sphincterotomy, add		107.30	1
E728	— with truncal or selective vagotomy, add		110.90	
E729	— with highly selective vagotomy, add		186.00	
S291	Choledochectomy for tumour (for reconstruction, refer to S281)	8	246.80	8
	Repair			
S292	Common duct stricture **dissection and/or resection** (for reconstruction, refer to S281)	7	125.20	10
S293	Biliary duct atresia, infant (see Preamble, Part B, paragraph 25)	8	I.C.	12
	PANCREAS			
Z762	Biopsy, needle (I.O.P.)		53.70	
	Incision			
Z577	Biopsy, incisional (I.O.P.)		78.70	7
S297	Drainage of acute pancreatitis or abscess or marsupialization of cyst(s)	7	225.40	7
	Excision			
	Pancreatectomy			
S298	Complete with splenectomy	9	858.60	13
S300	"Whipple type" procedure	9	858.60	13
S301	Local complete excision of tumour or lesion	8	314.80	8
S309	Distal — body, tail and splenectomy with or without anastomosis	9	658.30	11
	Repair			
S305	Pancreatic cyst — gastrostomy	7	386.40	8
S306	— duodenostomy	8	386.40	8
S307	— jejunostomy	8	386.40	8
S304	Lateral pancreatoduodenostomy or anastomosis of filleted pancreatic duct to intestine (Puestow)	9	525.90	10

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM

Code	**ABDOMEN, PERITONEUM AND OMENTUM**	Asst.	Surg.	Anaes.
			$	
Notes:	(1) When the laparoscope is used as a means of entrance to perform an intra abdominal procedure, no extra benefit for laparoscopy may be claimed. (2) When an exploratory laparotomy is performed followed by a colostomy through another incision in the abdomen, the colostomy should be claimed at 100% and the laparotomy at 85% of the listed benefit.			
	Paracentesis (I.O.P.)			
Z590	Aspiration for diagnostic sa.nple		16.45	
Z591	Aspiration with therapeutic drainage with or without diagnostic sample		30.05	4
E724	Administration of chemotherapy **or sclerosing agent,** add		7.15	
Z763	Paracentesis with lavage for diagnosis (I.O.P.)		25.00	4
	Incision			
Z563	Needle biopsy of peritoneum (I.O.P.)		25.00	
Z564	Open lavage of peritoneal cavity for diagnosis without manual exploration of peritoneal cavity (I.O.P.)		48.65	4
S312	Laparotomy, with or without biopsy (except biopsies of stomach, liver, pancreas and multiple para-aortic lymph nodes)	6	164.60	6
Note:	S312 — Use for division or removal of adhesions, if no other abdominal surgery performed. — may not be claimed with other intra-abdominal procedures (except for I.O.P.)			
E745	Insertion of tubes and post-operative continuous peritoneal lavage — when combined with any other abdominal procedure, add		61.90	
S321	Laparotomy for acute trauma	6	225.40	6
E733	with repair of intestine, single — add		93.00	3
E734	multiple **and**/or with resection, add		139.50	3
E735	with splenectomy, (partial or complete), add	2	186.00	3
E723	with repair of lacerated spleen, add	2	125.20	3
E736	with repair of lacerated liver, add	2	125.20	3
E739	with repair of diaphragm, add	2	78.70	2
	Peritoneal abscess			
S313	Subphrenic	7	239.70	7
S314	Abdominal	6	164.60	6
Z569	Pelvic abscess, incision drainage — rectal or vaginal approach (I.O.P.)		78.70	4
Z594	**Percutaneous abdominal abscess drainage including daily supervision**		150.25	

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM

Code	ABDOMEN, PERITONEUM AND OMENTUM – Cont'd	Asst.	Surg.	Anaes.
			$	
Z595	**Replacement of drainage catheter in abdominal recess**		28.60	
Z596	**Abscess drainage check**		14.30	
Z574	Removal of infected sutures from abdominal wall or re-exploration of wound for bleeding — general anaesthetic (I.O.P.)	4	61.90	4
S311	Umbilical vein intra-abdominal dissection and catheterization (for newborn see pg. 88)	6	150.25	6
S320	Insertion of antabuse into abdominal wall		37.60	
	Insertion of peritoneo-jugular shunt for ascites			
S203	— primary	7	186.00	7
S209	— revision	7	128.80	7
	Excision			
S316	Excision of full thickness abdominal wall tumour and primary closure (see Preamble, Part B, paragraph 25)		I.C.	6
S317	Umbilectomy — plastic	4	71.55	4
S318	Panniculectomy (requires O.H.I.P. authorization (see Surgical Preamble, paragraph 17)	6	279.00	6
E748	— with repair of umbilical hernia, add		68.00	
Note:	S318 includes any necessary diastasis repair.			
S319	Mesenteric cyst	6	214.65	6
	Endoscopy			
	Peritoneoscopy, **culdoscopy** or laparoscopy (I.O.P.)			
Z552	— without biopsy	4	71.55	6
Z553	— with biopsy and/or lysis of adhesions and/or removal of foreign body	4	93.00	6
	Repair			
S325	Omentopexy, sole operative procedure	6	153.80	6
	Herniotomy			
	Inguinal or femoral — single			
S326	— infants and children, with or without hydrocoele repair	4	164.60	4
S324	— adolescents and adults	4	186.00	4
S328	Unilateral with exploration of other side, infants and children	4	214.65	4
	Strangulated or incarcerated			
S329	— without resection of bowel	4	246.80	4
S330	— with resection of bowel	6	443.60	7

Code	ABDOMEN, PERITONEUM AND OMENTUM - Cont'd	Asst.	Surg. $	Anaes.
S331	Inguinal and femoral same side	4	254.00	4
E727	Hydrocoele repair, add to S324, S329, S330 or S331 — not applicable to infants or children		42.90	
S332	Umbilical — Adolescent or adult	4	200.30	4
S333	— Child (operative)	4	150.25	4
E756	**— with resection of strangulated hernia, add**		71.55	
E757	**— without resection of strangulated hernia, add**		35.80	
	Omphalocoele and gastrochisis			
S334	— one stage repair	7	239.70	7
	Multiple staged repair			
S335	(a) Gross method or Silon mesh	7	239.70	7
S336	(b) Second stage repair (completion of abdominal wall closure)	7	239.70	7
	Diaphragmatic/morgagni, other than oesophageal hernia			
S337	One stage procedure — trans-abdominal	7	329.10	9
S338	Trans-thoracic	9	329.10	13
S339	Second stage and abdominal closure	4	193.20	9
S340	Ventral — post-operative	6	239.70	6
S344	Massive incisional hernia	6	275.50	6
S345	Massive sliding inguinal hernia	6	225.40	6
E725	Recurrent — all types, excepting oesophageal, add	2	57.20	2
E726	Repeat recurrent inguinal hernia (more than 2 repairs), add to S324, S326, S329, S330 or S331	2	100.20	2
S342	Epigastric	4	153.80	4
	Suture			
S343	Secondary closure for evisceration (when sole abdominal operative procedure)	6	178.90	6

SURGICAL PROCEDURES

OPERATIONS ON THE UROGENITAL SYSTEM
OPERATIONS ON THE URINARY SYSTEM

Code	KIDNEY AND PERINEPHRIUM	Asst.	Surg. $	Anaes.
Notes:	(1) No additional claim should be made for nephroscopy when done at the time of pyelolithotomy or nephrolithotomy.			
	(2) In a routine surgical approach to the kidney and related procedures, no additional claim should be made for rib resection carried out for access purposes.			
	(3) When the kidney has been operated on more than one month previously, the fee for the second surgery may be increased by $55.10 (E752)			
	Incision			
Z601	Renal biopsy(s), unilateral, needle (I.O.P.)		58.70	4
S401	Drainage of kidney abscess	7	211.10	7
S402	Drainage of perinephric abscess	7	138.10	7
S403	Exploration of renal and peri-renal tissues (with or without biopsy or unroofing of cyst)	7	229.00	7
Note:	Use S403 for open renal biopsy. May not be claimed in addition to nephrectomy.			
	Nephrotomy			
S404	— with drainage — nephrostomy — when sole operative procedure	7	229.00	7
S405	—with removal of calculus	7	307.70	7
Z600	—change of nephrostomy tube (I.O.P.)		22.90	
S406	Transection of aberrant renal vessels — sole operative procedure	7	243.30	7
S407	Pyelotomy — with drainage	7	243.30	7
S408	— with removal of calculus	7	282.60	7
S409	— with diversion of urine	7	296.90	7
	Excision			
S410	Calycectomy with diversion of urine	7	325.55	7
S411	Partial or hemi-nephrectomy	7	343.40	7
S423	Partial or hemi-nephrectomy with total ureterectomy	7	375.60	7
	Nephrectomy			
S412	— ectopic kidney	7	296.90	7
S413	— lumbar	7	296.90	7
S415	— transperitoneal	7	336.30	7
S416	— thoraco-abdominal or radical nephrectomy	9	432.90	13
S417	— with gland dissection	9	450.80	13
S418	— with incision and repair of inferior vena cava for removal of tumour thrombus (see Preamble, Part B, paragraph 22)	I.C.	I.C.	I.C.
S419	Nephro-ureterectomy, total, without resection of uretero-vesical junction	7	336.30	10

SURGICAL PROCEDURES

OPERATIONS ON THE UROGENITAL SYSTEM
OPERATIONS ON THE URINARY SYSTEM

Code	KIDNEY AND PERINEPHRIUM – Cont'd	Asst.	Surg. $	Anaes.
S420	Nephro-ureterectomy, total, with resection of uretero-vesical junction	7	379.20	10
S421	Excision of stenosed renal artery with re-implanation or homograft	7	504.40	15
	Repair			
S422	Pyeloplasty (with or without nephropexy)	7	336.30	7
E754	— with removal of calculus, add		37.90	
S426	Nephropexy — when sole operative procedure	7	243.30	7
S428	Symphysiotomy, for horseshoe kidney with or without nephropexy and associated procedures	7	282.60	7
	Suture			
S429	Ruptured or lacerated kidney — repair or removal	7	282.60	7
S430	Removal of staghorn calculus filling renal pelvis and calyces to include x-ray control	7	422.10	9
	Extra Renal Procedures			
S431	Excision of retroperitoneal tumour	7	243.30	7
S432	Exploration retroperitoneal tumour	7	168.10	7
S433	Sacro-coccygeal teratoma	6	282.60	6
	Renal Transplantation Procedures: (submit on recipient's claim) These benefits do not include immuno-suppresive therapy which is on a "fee for service" basis.			
S435	Kidney transplant (surgical team benefit)		765.60	13
S434	Kidney re-transplant (surgical team benefit)		915.80	13
S436	Donor nephrectomy — surgical team benefit, unilateral or bilateral (to include renal perfusion with hypothermia)	7	296.90	8
E753	— live donor, add		84.40	
Note:	For nephrological components of the above, see Diagnostic and Therapeutic Procedures.			
S437	Renal autotransplantation		572.40	10
	URETER			
	Endoscopic Procedures			
S470	Cystoscopy with manipulation and/or removal of calculus and retrograde pyelogram if required		153.80	4
	Incision			
S442	Peri-ureteral abscess	6	138.10	6

SURGICAL PROCEDURES

OPERATIONS ON THE UROGENITAL SYSTEM
OPERATIONS ON THE URINARY SYSTEM

Code	URETER – Cont'd	Asst.	Surg. $	Anaes.
	Ureterotomy, abdominal or vaginal exploratory or for drainage			
S443	— upper 2/3	6	168.10	6
S444	— lower 1/3	6	243.30	6
	with removal of calculus			
S445	— upper 2/3	6	239.70	6
S446	— lower 1/3	6	307.70	6
	where ureter has been previously opened			
S447	— upper 2/3	6	282.60	6
S448	— lower 1/3	6	336.30	6
	Excision			
S449	Ureterectomy — including uretero-vesical junction	6	282.60	7
S450	— other	6	211.10	7
	Repair			
S451	Uretero-vesical anastomosis or re-implantation unilateral	6	282.60	8
S561	Re-implantation of ureter with extensive tapering	6	422.10	8
S562	Bifid ureter	6	307.70	8
S452	Uretero-ileal conduit	6	504.40	9
S453	Uretero-ileal conduit with total cystectomy	9	801.40	15
S454	Uretero-ileal conduit with ureterectomy and ileal replacement	6	572.40	7
	Uretero-intestinal anastomosis or transplant			
S455	— unilateral	6	211.10	6
S462	— bilateral	6	282.60	6
S456	— bilateral with cystectomy, one stage	9	629.60	13
S457	Uretero-ureterostomy	6	354.20	8
S458	Ureterostomy — cutaneous — unilateral	6	168.10	6
S463	— with lower third ureterotomy	6	243.30	6
S459	Uretero-vaginal fistula	6	364.90	6
S460	Ureterolysis for peri-ureteral fibrosis unilateral	6	282.60	6
S461	Ureteroplasty (Hutch) — unilateral	6	211.10	6
S427	Bladder flap (Baori) — to include re-implantation of ureter	6	322.00	6
	Suture			
	Spontaneous or traumatic rupture or transection			
S465	— immediate — upper 2/3	6	243.30	6
S466	— lower 1/3	6	282.60	6
S467	— late repair — upper 2/3	6	282.60	6
S468	— lower 1/3	6	307.70	7

SURGICAL PROCEDURES

OPERATIONS ON THE UROGENITAL SYSTEM
OPERATIONS ON THE URINARY SYSTEM

Code	**BLADDER**	Asst.	Surg.	Anaes.
Note:	(1) No extra claim may be made for EUA when done at the time of cystoscopy. (2) Visit benefits only, as applicable, may be claimed for changing a suprapubic tube. (3) No additional claim should be made for suprapubic cystotomy when performed in the routine course of gynaecological surgery.		$	
	Endoscopy — Cystoscopy			
	Diagnostic Procedures (I.O.P.)			
Z606	Diagnostic with or without urethroscopy (Panendoscopy)		47.20	4
Z607	Repeat within 30 days		22.90	4
Z608	With catheterization of ureters with or without hydrodistension of the bladder, brush biopsy of bladder, collection of ureteral specimens, intravenous function test and retrograde injection of opaque media and calibration and/or dilatation of the ureter — one or both sides		57.20	4
Z610	With transurethral biopsy, brush biopsy of renal pelvis and/or ureter and/or insertion of ureteral stent		64.40	4
Z612	With manometry (to include urethral pressure profile if required)		55.10	4
Z613	With meatotomy or internal urethrotomy		52.90	4
Z614	With meatotomy and retrograde pyelogram		64.40	4
Z615	With needle biopsy of prostate		68.70	4
	Therapeutic Procedures			
S492	With electrocoagulation — tumour(s)		76.55	4
S493	— Hunner ulcer		76.55	4
	With excision of tumour or tumours including base and adjacent muscles and electrocoagulation if necessary			
S494	Single tumour 1 to 2 cm. diameter		175.30	4
S495	Single tumour over 2 cm. diameter		282.60	4
S496	Multiple tumours		282.60	4
S497	With resection bladder neck, female		110.90	4
S498	With resection bladder neck, male		211.10	5
S499	With electro surgical ureteral meatotomy		110.90	4
S500	With removal foreign body or calculus		110.90	4
S501	With removal of ureteric catheter		48.30	4
E751	With insertion of radioactive substance, in addition to associated procedures (Z606 to S500)		35.80	

SURGICAL PROCEDURES

OPERATIONS ON THE UROGENITAL SYSTEM
OPERATIONS ON THE URINARY SYSTEM

Code	BLADDER - Cont'd	Asst.	Surg. $	Anaes.
S502	With secondary surgical evacuation of bladder clots and control of haemorrhage		54.70	4
Note:	Z608 to S502 — "with" means the listed benefit includes the cystoscopy.			
	Introduction (I.O.P.)			
	Catheterization: acute retention, change of retention catheter or instillation of medication			
Z602	— office		5.50	
Z603	— home		10.40	
Z611	— hospital		5.50	
U.V.C.	— change of suprapubic tube		visit fees	
	Incision			
Z605	Aspiration (I.O.P.)		8.00	
S478	Cystotomy or cystostomy (see Note (3) page 196)	5	138.10	5
S479	Cystotomy or cystostomy and electrocoagulation of tumour	5	211.10	5
S480	Cystotomy with trochar and cannula and insertion of tube		54.70	5
E750	— when done in conjunction with another procedure, add		16.80	
S481	Cystolithotomy — when sole operative procedure	5	168.10	5
S476	Cutaneous vesicostomy	5	282.60	5
S477	Reduction cystoplasty (bladder plication)	5	229.00	5
	Excision			
	Cystectomy			
S482	Partial for tumour or diverticulum (single or multiple)	6	243.30	6
S483	— with re-implantation of ureter	6	354.20	7
S490	— with re-implanation of ureters	6	468.65	7
S484	Complete cystectomy, without transplant	6	422.10	10
S485	— with uretero-intestinal transplant	8	629.60	13
S453	— with uretero-ileal conduit	9	801.40	15
S471	Excision of urachal cyst or sinus with or without umbilical hernia repair	6	189.60	6
S487	Excision of urachus, repair of bladder and diversion of urine	6	189.60	6
S488	Extrophy-excision of bladder and repair of abdominal wall, inclusive of graft	6	138.10	6
S489	— above including bilateral ureterosigmoidostomy	6	422.10	6

SURGICAL PROCEDURES

OPERATIONS ON THE UROGENITAL SYSTEM
OPERATIONS ON THE URINARY SYSTEM

Code	BLADDER - Cont'd	Asst.	Surg. $	Anaes.
S491	Plastic repair of extrophy using bladder and including skin flaps	6	422.10	6
	Repair			
S512	Repair of ruptured bladder	5	211.10	6
S513	Cystoplasty, using intestine	8	422.10	9
	Plastic repair of bladder neck			
S518	— child	5	211.10	5
S519	— adolescent or adult	5	282.60	5
S520	With diverticulectomy	5	354.20	7
	Destruction			
S521	Litholapaxy and removal of fragments		138.10	4
	Suture			
	Closure of fistula			
S522	External, suprapubic	4	168.10	4
S523	Vesico-vaginal — vaginal approach	4	286.20	6
S524	— transvesical approach — with or — without omental flap	5	296.90	6
Note:	See also S734, S711 on page 205.			
S525	Vesico-rectal or vesico-sigmoid	5	289.80	6

URETHRA

Preamble

(1) No charge should be made for pre-cystoscopy dilitation of the male urethra unless urethral stricture is the primary diagnosis. No charge should be made for dilation of the female urethra when done at the same time as cystoscopy.

Code		Asst.	Surg. $	Anaes.
	Endoscopy			
Z617	Urethroscopy — diagnostic (I.O.P.)		22.90	4
Z618	— with biopsy (I.O.P.)		50.10	4
S547	Removal of foreign body or calculus		110.90	4
	Incision			
Z616	Biopsy of urethra (without endoscopy) (I.O.P.)		15.40	4
S530	Urethrotomy — external	3	138.10	4
S532	— transurethral (visual)	3	211.10	4
S531	Urethrostomy	3	138.10	4

Code	URETHRA - Cont'd	Asst.	Surg. $	Anaes.
Z604	Meatotomy and plastic repair (I.O.P.)		20.40	4
S533	For extravasation of urine with multiple drainage	3	138.10	4
S534	— above with external urethrotomy or cystotomy	3	211.10	4
Z609	Peri-urethral abscess (I.O.P.)		20.40	4
	Excision			
S536	Caruncle	3	54.70	4
S537	Urethral papilloma, single or multiple		54.70	4
S541	Diverticulectomy — male or female	3	168.10	4
S542	Posterior urethral valve	4	168.10	4
S543	Prolapse urethra, excision	3	54.70	4
S544	Urethrectomy — radical	4	138.10	4
	Repair			
S548	Urethral sling	4	243.30	4
S549	Retropubic urethropexy (e.g. Marshall Marchetti, Burch) for stress incontinence — primary procedure	4	198.90	5
S546	— repeat procedure for failed retropubic or vaginal surgery for stress incontinence	4	229.00	6
Note:	See also S731-S733, page 207.			
S559	Prosthetic procedure for urinary incontinence (e.g. Kauffman, Rosen type, etc.)	3	243.30	5
S560	— where perineum has been previously operated on for incontinence	3	282.60	5
S563	— removal of perineal incontinence prosthesis	3	92.30	4
	Urethroplasty			
	1st stage —			
S545	— posterior	4	243.30	6
S550	— anterior	4	183.90	4
S558	2nd stage —	4	149.50	4
S535	One stage repair (to include skin graft if necessary	4	243.30	6
	Suture			
S551	Rupture, anterior urethra (diversion of urine extra)	4	110.90	4
S552	Posterior urethra — immediate repair	4	282.60	4
S553	— late repair	4	354.20	5
	Fistula			
S554	Penile urethra (diversion of urine extra)		59.00	4
S555	Perineal urethra	4	211.10	4
S556	Recto-urethral with diversion, colostomy and closure of colostomy	6	354.20	7
	Destruction			
S557	Urethro-vesicolysis — when sole operative procedure	3	138.10	4
S564	Transurethral incision or resection of external sphincter (when sole operative procedure)		211.10	4

SURGICAL PROCEDURES

OPERATIONS ON THE UROGENITAL SYSTEM
OPERATIONS ON THE URINARY SYSTEM

Code	**URETHRA – Cont'd**	Asst.	Surg. $	Anaes.
	Manipulation (I.O.P.)			
Note:	No claim should be made for pre-cystoscopy dilation of the male urethra unless urethral stricture is the primary diagnosis. No claim should be made for dilation of the female urethra when done at the same time as cystoscopy.			
	Dilation of stricture, male (Passage of Sounds)			
Z621	— local anaesthetic		7.00	
Z619	— general anaesthetic		33.60	4
Z622	Dilation of urethra, female		3.60	
Z620	— under general anaesthetic		26.80	4

SURGICAL PROCEDURES

OPERATIONS ON THE MALE GENITAL SYSTEM

Code		Asst.	Surg. $	Anaes.
	PENIS			
	Incision — Slit of prepuce (complete care)			
S567	Newborn		9.30	
S568	Infant		13.80	4
S569	Adult or child		19.30	4
	Excision			
S570	Circumcision — newborn (complete care)		22.90	
S571	— infant		33.60	4
S572	— adult or child	3	54.70	4
Z702	Biopsy (I.O.P.)		15.40	4
	Amputation			
S574	Partial	4	110.90	4
S575	Partial with inguinal glands 1 or 2 stages	4	282.60	5
S576	Radical with inguinal and femoral glands 1 or 2 stages	6	354.20	7
Z701	Condylomata (I.O.P)			
	— local anaesthetic		21.10	
Z767	— general anaesthetic		50.10	4
S599	Excision plaque for Peyronies disease	4	133.80	4
	— where grafting is necessary, add appropriate skin graft benefit.			
	Repair			
S577	Epispadias	3	211.10	4
	Hypospadias			
S578	One stage repair	4	211.10	4
S579	Chordee repair	4	138.10	4
S580	Plastic reconstruction, urethra	4	211.10	4
S581	Closure urethro-cutaneous fistula		59.00	4
S597	Penile prosthesis for impotence	4	196.80	4
E755	**— with inflatable prosthesis add**		**35.80**	
S588	**Surgical removal of prosthesis**	4	71.55	4
	TESTIS			
	Incision			
Z703	Abscess (I.O.P.)		35.80	4
Z704	Biopsy (I.O.P.) — single		35.80	4
Z705	— bilateral		53.70	4
Z706	— with vasography (see also page 81)		76.55	4
S589	Orchidectomy — unilateral	3	110.90	4
S590	Radical removal lymph nodes for testicular tumour	6	354.20	8
S598	Radical orchidectomy for malignancy — unilateral	3	149.50	4

SURGICAL PROCEDURES

OPERATIONS ON THE MALE GENITAL SYSTEM

Code		Asst.	Surg.	Anaes.
	TESTIS - Cont'd		$	
	Repair			
S591	Orchidopexy, any type, one or two stages to include hernia repair where required	4	211.10	4
S592	— second stage (Torek) repair		35.80	4
S593	Exploration for undescended testicle, without orchidopexy	4	168.10	4
S594	Reduction of torsion of testis or appendix testis and repair	3	149.50	4
S595	Ruptured testicle	3	110.90	4
S596	Insertion of testicular prosthesis	3	110.90	4
	EPIDIDYMIS			
	Incision			
Z707	Abscess (I.O.P.)		35.80	4
	Excision			
S601	Spermatocoele or spermatic granuloma	3	110.90	4
S602	Epididymectomy — unilateral	3	110.90	4
	Repair			
S606	Anastomosis Epididymovasostomy — unilateral	3	110.90	4
	TUNICA VAGINALIS			
	Incision			
Z708	Hydrocoele aspiration (I.O.P.)		10.40	
	Excision			
S611	Hydrocoele — unilateral	4	110.90	4
Note:	When done with hernia repair use E727.			
	SCROTUM			
	Incision			
	Abscess or haematocoele (I.O.P.)			
Z709	— local anaesthetic		12.50	
Z768	— general anaesthetic		35.80	4
S616	— and exploration — unilateral	3	54.70	4
	Excision			
S618	Resection of scrotum	3	138.10	4
	Suture			
S619	Trauma — laceration — depending on extent and complications (see Preamble, Part B, paragraph 25)		I.C.	I.C.

SURGICAL PROCEDURES

OPERATIONS ON THE MALE GENITAL SYSTEM

Code		Asst.	Surg.	Anaes.
	SCROTUM - Cont'd **VAS DEFERENS**		$	
	Incision			
Z710	Vasography (I.O.P.)		35.80	4
	Repair			
S624	Anastomosis, unilateral	3	138.10	4
S625	— including biopsy and vasography	3	168.10	4
	Suture			
S626	Ligation — uni or bilateral (vasectomy)	3	68.70	4
	SPERMATIC CORD			
	Excision			
S630	Hydrocoele — single	3	110.90	4
Note:	When done with hernia repair use E727.			
S631	Varicocoele (abdominal or scrotal approach) — single	3	110.90	4
	SEMINAL VESICLES			
	Incision			
Z711	Abscess (I.O.P.)		76.55	4
	Excision			
S636	Vesiculectomy	3	354.20	4
	PROSTATE			
Note:	A T.U.R. followed within 10 days by a bilateral orchidectomy because of carcinoma of the prostate should be claimed in accordance with paragraph (3) of the Surgical Preamble.			
	Incision			
Z712	Biopsy, needle (I.O.P.)		50.10	4
Z713	— with drainage abscess (I.O.P.)	3	58.70	4
S644	Biopsy, perineal, open operation	3	138.10	4
	Removal of calculus (with or without biopsy)			
S642	— perineal	4	282.60	4
S643	— retropubic	4	282.60	4

SURGICAL PROCEDURES

OPERATIONS ON THE MALE GENITAL SYSTEM

Code	**PROSTATE - Cont'd**	Asst.	Surg. $	Anaes.
	Excision			
	Prostatectomy (not to include investigative cystoscopy) but to include vasectomy when indicated.			
S645	Perineal	6	282.60	6
S646	Perineal with vesiculectomy	8	432.90	11
	Suprapubic (with or without removal of bladder calculi)			
S647	— one stage	5	296.90	6
S648	— two stages — 1st stage	5	138.10	6
S649	— 2nd stage	5	168.10	6
	Retropubic (with or without removal of bladder calculi)			
S650	— simple	5	296.90	6
S651	— radical	5	457.90	6
S641	Transpubic total prostatovesiculectomy with pelvic lymph node dissection (includes laparotomy when necessary)	8	572.40	11
S652	Staging pelvic lymphadenectomy for prostatic cancer	7	211.10	7
	Endoscopy (cystoscopy included.)			
S655	Transurethral resection of prostate (no additional benefit for cystoscopy, meatotomy, dilatation of stricture, internal urethrotomy or vasectomy when done at the same time)		304.10	6
S654	Transurethral resection of prostate for residual or regrowth of tissue within one year of previous prostatectomy by same surgeon		203.90	6
S656	Transurethral drainage of abscess, complete care		54.70	5

SURGICAL PROCEDURES

OPERATIONS ON THE FEMALE GENITAL SYSTEM

Preamble

(1) In composite operations such as anterior and posterior repair and D. & C. or anterior and posterior repair and cauterization of cervix and biopsy, the benefit shall, unless otherwise mentioned below, be that of the major procedures.

(2) If a D & C is part of the normal procedure carried out by the surgeon prior to other gynaecological surgery, no extra benefit should be claimed for the D & C. If the D & C is done because of disease or for therapeutic reasons prior to other gynaecological surgery, the D & C should be claimed at 85% of the listed benefit in keeping with paragraph (3) of the Surgical Preamble.

(3) If culdoscopy is performed as part of a sterilization procedure, no extra claim should be made for the culdoscopy.

Code	VULVA AND INTROITUS	Asst.	Surg. $	Anaes.
	Incision			
S700	Hymenotomy		35.80	4
	Abscess of vulva, Bartholin or Skene's gland (I.O.P.) — incision and drainage			
Z714	— local anaesthetic		11.80	
Z715	— general anaesthetic	3	34.30	4
Z716	Marsupialization of Bartholin's cyst or abscess (I.O.P.) (includes Z714 or Z715)	3	48.10	4
Z717	Perineotomy (I.O.P.)		11.80	
	Excision			
	Biopsy(s) — when sole procedure (I.O.P.)			
Z477	— local anaesthetic		13.20	
Z475	— general anaesthetic	3	34.30	4
S707	Hymenectomy (with or without perineotomy)		48.10	4
S706	Cyst of Bartholin's gland	3	89.40	4
	Condylomata — single or multiple (I.O.P.)			
Z733	Chemical and/or cryosurgery — one or more		7.50	
	Surgical excision or electrodessication			
Z736	— local anaesthetic		19.70	
Z769	— general anaesthetic		48.10	4
	Vulvectomy			
S703	Simple —	4	171.70	4
S704	Radical — without gland dissection	6	288.50	6
E850	— with bilateral inguinal node dissection with or without skin graft, add		135.90	1
E851	— with bilateral common iliac node dissection with skin graft, add		189.60	2

SURGICAL PROCEDURES

OPERATIONS ON THE FEMALE GENITAL SYSTEM

Code		Asst.	Surg. $	Anaes.
	VULVA AND INTROITUS – Cont'd			
	Repair			
S708	Non obstetrical injury to vulva and/or vagina, and/or perineum (see Preamble, Part B, paragraph 25) . . .		I.C.	I.C.
S705	Ligation — of varicose vein of labia		48.10	4
	VAGINA			
	Endoscopy			
Z478	Vaginoscopy (pre menarchal) with or without medication (I.O.P.)		34.30	4
Note:	**Culdoscopy — see p. 188**			
	Incision			
S712	Culdotomy, drainage or needle puncture		48.10	4
S713	Culdotomy, incision and exploration	3	89.40	4
Z728	Incision and drainage of cyst, abscess or haematoma .		34.30	4
U.V.C.	Vaginal insufflation		visit fees	
	Excision			
	Biopsy(s) — when sole procedure (I.O.P.)			
Z722	— local anaesthetic		13.20	
Z723	— general anaesthetic		34.30	4
S715	Excision of cyst(s), or benign tumour(s)	3	89.40	4
S742	Colpectomy — e.g., for carcinoma	4	254.00	6
S702	Excision of congenital vaginal septum	3	89.40	4
	Repair			
S716	Anterior or posterior repair	4	125.20	5
S717	Anterior and posterior repair	4	196.80	5
S718	Anterior, posterior repair and repair of enterocoele and/or vault proplapse	4	233.50	5
S719	Posterior repair and repair of enterocoele and/or vault prolapse	4	206.10	5
S723	Posterior repair and repair of anal sphincter	4	164.85	5
S720	Anterior repair (with or without posterior repair) and repair of uterine prolapse (Fothergill or Watkin's interposition)	4	233.50	5
S721	Anterior, posterior repair with excision of cervical stump	4	233.50	6
S722	Post hysterectomy vault prolapse and/or enterocoele, with or without anterior and posterior repair — vaginal and/or abdominal approach	4	233.50	6
S724	Perineorrhaphy	3	82.40	4
Note:	May not be claimed with delivery or with other vaginal surgery procedures.			

SURGICAL PROCEDURES

OPERATIONS ON THE FEMALE GENITAL SYSTEM

Code	VAGINA – Cont'd	Asst.	Surg.	Anaes.
			$	
S725	Colpocleisis (Le Fort or modification)	5	186.00	5
S726	Construction of artificial vagina (see Preamble, Part B, paragraph 22) (see also Appendix D)	4	I.C.	6
	Closure of fistula			
S523	Vesico-vaginal — single surgeon	4	286.20	6
S734	— two surgeons — vaginal surgeon	4	199.20	6
S711	— abdominal surgeon		199.20	
Note:	See also S524, page 196.			
S231	Recto-vaginal (any repair)	4	225.40	6
S729	Uretero-vaginal	6	350.30	6
S709	Urethro-vaginal	4	250.70	4
	Retropubic urethropexy (e.g. Marshall Marchetti) for stress incontinence			
S549	**— primary procedure**	**4**	**198.90**	**4**
S546	**— repeat procedure for failed retropubic or vaginal surgery for stress incontinence**	4	229.00	6
	Retropubic urethropexy-combined abdominal-vaginal procedure for stress incontinence (sling procedure) — following previous failed procedures			
S731	— one surgeon	6	288.50	7
S732	— two surgeons — vaginal surgeon	6	171.70	7
S733	— abdominal surgeon		233.50	
S748	— one surgeon following two or more failed procedures	6	412.10	7
	— two surgeons following two or more failed			
S749	procedures — vaginal surgeon	6	233.50	7
S751	— abdominal surgeon		288.50	
	Manipulation			
	Examination and/or dilatation — when sole procedure			
Z718	General anesthetic (I.O.P.)		34.30	4
Note:	Removal of I.U.D. under g.a.; use Z718.			
U.V.C.	Removal of I.U.D. without g.a.		visit fees	
	CERVIX UTERI			
	Endoscopy			
Z731	Initial investigation of abnormal cytology under colposcopic technique (to include biopsies and curetting) (I.O.P.)		34.30	
Z730	**Follow up** Colposcopy (I.O.P.)		5.90	
	Cauterization (I.O.P.)			
U.V.C.	Chemical		visit fees	
Z732	Cryotherapy		11.70	
Z724	Electrocautery		5.90	
Z725	Dilatation and cauterization under general anaesthesia		34.30	4

SURGICAL PROCEDURES

OPERATIONS ON THE FEMALE GENITAL SYSTEM

Code	**CERVIX UTERI - Cont'd**	Asst.	Surg. $	Anaes.
	Conization			
S744	Knife conization with or without diagnostic curettage (residual stump)	3	116.80	4
Z729	Cryoconization, electroconization or CO_2 laser therapy with or without curettage — for premalignant lesion (moderate or severe dysplasia or carcinoma in situ) previously proven by biopsy (I.O.P.)		25.00	4
	Excision			
Z720	Biopsy — with or without fulgurization (I.O.P.)		11.70	4
S765	Amputation of cervix	4	125.20	4
S766	Cervical stump — abdominal	6	171.70	6
S767	— vaginal	4	171.70	4
Note:	Excision of cervical polyp(s) under general anaesthesia, use Z720.			
U.V.C.	Cervical polyp without g.a.		visit fees	
	Repair			
S774	Tracheloplasty for incompetent cervix	3	68.70	4
S750	Trachelorrhaphy (plastic repair of cervix) — not immediately following delivery	3	68.70	4
	CORPUS UTERI			
	Endoscopy (I.O.P.)			
Z583	Hysteroscopy with or without biopsy		58.40	
Z585	— with cannulization of tubes		68.70	
	Incision and Excision			
Z719	Endometrial biopsy — suction or curette — endometrial cytology — wash or brush (I.O.P.)		11.70	
Z581	Office endometrial curettage (I.O.P.)		24.00	
	Abortion-complete-under 20 weeks		visit fees	
Z770	— incomplete — including D & C (I.O.P.)		48.10	4
S752	— therapeutic curettage intra amniotic injection (complete)		75.55	4
S785	**— therapeutic intra amniotic injection (incomplete) followed by curettage**		123.60	4
S756	— missed abortion		75.55	4
S770	— hysterotomy — abdominal or vaginal	6	168.10	6
S783	— hysterotomy — abdominal or vaginal, with tubal interruption	6	193.20	6

See note on page 207.

SURGICAL PROCEDURES

OPERATIONS ON THE FEMALE GENITAL SYSTEM

Code	CORPUS UTERI - Cont'd	Asst.	Surg. $	Anaes.
Note:	**The presentation of a case for abortion before a Hospital Committee is not a benefit of OHIP.** **A pre-operative consultation by a second gynaecologist, when required by the hospital is not a benefit of OHIP**			
S754	Diagnostic curettage (with or without cauterization, biopsy of cervix, removal of polypi, Rubin's test or hysterosalpingography)		64.40	4
	Intracavitary application of radium or sealed sources including D.&C. carried out at same time as application (to include consultation fee)			
S753	— first application		123.60	4
S755	— repeat application (within 30 days)		61.80	4
S764	Myomectomy	6	233.50	6
	Hysterectomy (with or without adnexa)			
S757	Total or subtotal — abdominal or vaginal	6	288.50	6
S758	— with anterior and posterior vaginal repair including enterocoele and/or vault prolapse	6	412.10	6
S759	— with anterior or posterior vaginal repair including enterocoele and/or vault prolapse	6	350.30	6
S710	— with omentectomy for malignancy	6	350.30	6
S769	Radical (Schauta) — vaginal (includes R912)	8	412.10	8
S763	Radical (Wertheim's) (includes R912)	8	460.20	8
	Repair			
S771	Hysteropexy (uterine suspension)	6	171.70	6
S772	— with anterior and posterior vaginal repair	6	233.50	6
S773	— with anterior or posterior vaginal repair	6	206.10	6
	Hysteroplasty			
S779	Excision of septum (Strassman)	6	233.50	6
S775	Unification of double uterus	4	288.50	4
S777	Uterine inversion, operative	4	233.50	6
S778	Presacral neurectomy (with or without ovarian neurectomy)	6	233.50	6

SURGICAL PROCEDURES

OPERATIONS ON THE FEMALE GENITAL SYSTEM

Code		Asst.	Surg.	Anaes.
	FALLOPIAN TUBE		$	
	Excision, Suture or Repair			
S784	Ectopic pregnancy (surgical management)	6	212.90	6
E852	**— with tuboplasty, add**		20.60	
S738	Salpingectomy and salpingo-oophorectomy (uni or bilateral)	6	212.90	6
S741	**Tubal occlusion/interruption/removal by any method of approach for the purpose of sterilization**	6	116.80	6
	Tubal plastic operation **with or without operating microscope**			
S735	Fimbriolysis — unilateral or bilateral	6	164.85	6
S736	Salpingostomy — unilateral or bilateral	6	199.20	6
S739	Fimbriolysis and salpingostomy — unilateral or bilateral	6	250.40	6
S737	Hysterosalpingostomy (anastomosis of tubes to uterus)	6	288.50	6
S740	Resection of portion of tubes and re-anastomosis	6	288.50	6
S743	Repair of extensive tubal and peritubal disease for infertility using operating microscope **not to be charged for reconstruction following previous sterilization procedure — unilateral**	8	357.20	8
S728	**— bilateral**	8	429.30	8
	OVARY			
	Excision (unilateral or bilateral)			
S780	Biopsy of ovaries by laparotomy	5	164.85	6
S781	Wedge resection of ovaries (e.g. Stein-Leventhal)	5	171.70	6
S745	Oophorectomy	6	199.20	6
S782	Oophorectomy with total omentectomy	6	233.50	6
S746	Oophorocystectomy	6	199.20	6
S747	Para ovarian cystectomy	6	199.20	6
S714	**Second look exploratory laparotomy including biopsies, when done as part of chemotherapy protocol for ovarian carcinoma with or without total omentectomy**	**6**	**288.50**	**6**

SURGICAL PROCEDURES

OPERATIONS ON THE ENDOCRINE SYSTEM

Code		Asst.	Surg.	Anaes.
	THYROID GLAND		$	
	Incision			
Z726	Aspiration, thyroid cyst (I.O.P.)		18.80	
Z727	Percutaneous silicone core needle biopsy, (I.O.P.)		37.60	6
Z771	Aspiration biopsy, thyroid gland or nodule fine needle method (I.O.P.)		18.80	
S786	Abscess, complete care		53.70	4
	Excision			
	Biopsy			
S787	Surgical	4	135.90	6
	Thyroidectomy			
S788	Total	6	397.10	8
S789	Subtotal	6	314.80	7
S790	Hemi	6	236.10	7
E880	—Parathyroid(s) identification and re-implantation, add		125.20	
E881	**— splitting of sternum, if required, add**		53.70	
S791	Excision of solitary nodule	6	196.80	6
	PARATHYROID, THYMUS AND ADRENAL GLANDS			
	Excision			
S795	Exploration and/or removal, parathyroids or parathyroid tumour	6	397.10	8
S796	— if requiring splitting of sternum	10	450.80	13
E880	—Parathyroid(s) identification and re-implantation, add		125.20	
S797	Thymectomy	10	400.70	13
	Adrenalectomy or exploration			
S798	— unilateral	10	293.35	10
S799	— bilateral, with or without oophorectomy	10	450.80	11
S800	Adrenalectomy — unilateral for Pheochromocytoma	10	382.80	13
Z772	Thymus transplant (I.O.P.)		53.70	4

SURGICAL PROCEDURES

OPERATIONS ON THE NERVOUS SYSTEM

Code		Asst.	Surg. $	Anaes.
N100	Hypothermia — when employed, basic units for any procedure on nervous system			25
	BRAIN			
	Astrocytoma, oligodendroglioma, glioblastoma or metastatic tumour			
	Craniotomy plus excision			
N103	— supratentorial	11	714.35	15
N151	— infratentorial	11	824.25	15
N152	Craniotomy plus lobectomy	11	748.70	15
E901	— with operating microscope, add		144.20	
	Meningioma and other tumourous lesions			
	Craniotomy plus excision			
N102	— supratentorial	11	824.25	15
N153	— infratentorial or basal	11	1071.50	15
E901	— with operating microscope, add		144.20	
E902	Lesion greater than 4 cm diameter, add to N102, N153		250.70	
E903	Team fee for acoustic neuroma, same approach add		412.10	
	Intracranial aneurysm repair			
N105	Carotid circulation	11	879.20	15
N154	Vertebrobasilar circulation (including aneurysm of vein of Galen)	11	913.55	15
E901	— with operating microscope, add		144.20	
	Cerebral arteriovenous malformation			
	Craniotomy for obliteration and/or excision			
N106	— supratentorial	11	879.20	15
N155	— infratentorial	11	913.55	15
E901	— with operating microscope, add		144.20	
E908	Removal of intracerebral and/or subdural hematoma in conjunction with a ruptured intracranial aneurysm or arteriovenous malformation, add to N105, N106, N154, N155		154.50	
N107	Extracranial approach, including balloon catheter or embolization techniques	11	573.50	15
	Extracranial-intracranial microvascular anastomosis			
N218	Superficial temporal artery	11	789.90	15
N156	Occipital artery	11	824.25	15
E904	Posterior fossa add		161.40	
E905	Use of graft (autogenous vessel or synthetic) add		144.20	

SURGICAL PROCEDURES

OPERATIONS ON THE NERVOUS SYSTEM

Code	BRAIN – Cont'd	Asst.	Surg. $	Anaes.
N121	Extracranial-intracranial long venous bypass (from internal carotid in the neck or any of the trunk vessels in the neck or chest to a major intracerebral vessel, i.e. vertebral, internal carotid, middle cerebral)	11	1147.10	15
	Carotid-cavernous fistula			
N108	Intracranial obliteration (to include combined cervical and intracranial procedure)	11	824.25	15
N118	Extracranial approach, including balloon catheter or embolization techniques	11	501.40	15
	Spontaneous intracerebral hemorrhage			
	Craniotomy plus removal			
N104	— supratentorial	11	590.70	15
N157	— infratentorial	11	662.80	15
N120	Burr hole plus drainage	11	322.80	15
	Intracranial cyst			
	Craniotomy plus evacuation (to include interventriculostomy)			
N158	— supratentorial	11	590.70	15
N159	— infratentorial	11	680.00	15
N160	Burr hole plus aspiration	11	267.90	15
	Brain abscess:			
N117	Craniotomy	11	714.35	15
N115	Burr hole and aspiration	7	357.20	7
Z818	Subsequent aspiration through existing burr hole within 30 days (I.O.P.)		144.20	
N113	Craniotomy for brain biopsy (other than for tumour)	11	412.10	11
N109	Hemispherectomy	11	968.50	15
N110	Lobectomy and/or excision of cortical scar for epilepsy	11	1071.50	15
N130	Craniotomy plus midline commissurotomy	11	680.00	15
N128	Repair of encephalocoele	11	535.80	15
N129	Posterior fossa decompression for Arnold Chiari malformation	11	645.70	15
N123	Stereotaxis — intracranial (to include ventriculography)	11	535.80	11

SURGICAL PROCEDURES

OPERATIONS ON THE NERVOUS SYSTEM

Code	**BRAIN – Cont'd**	Asst.	Surg. $	Anaes.
N119	Intracranial implantation of chronic surface electrodes	11	604.45	11
Z823	Implantation, removal or revision of stimulation pack (I.O.P.)		178.60	
Z824	Removal of chronic surface or depth electrodes (I.O.P.)		178.60	
Z813	Burr hole plus needling of brain for biopsy (I.O.P)	7	199.20	7
Z806	Ventriculogram (including burr holes, air or positive contrast) (I.O.P.)		89.30	
Z802	Ventricular puncture through previous burr hole or fontanelle, or puncture and/or aspiration of cisterna magna (I.O.P.)		54.95	7
Z825	Ventriculoscopy (to include burr hole) (I.O.P.)		212.90	7
E916	With biopsy add		89.30	
E917	With interventriculostomy add		89.30	
E918	With removal of foreign body add		89.30	
Z819	External ventricular drainage (I.O.P.)	5	144.20	5
Z820	Insertion of intracranial catheter or transducer for purposes of monitoring (I.O.P.)	5	212.90	5
Z812	Subsequent revisions or replacements within 30 days (I.O.P.) each	5	144.20	5
N127	Re-opening of craniotomy for post-operative haematoma or infection, or for removal of bone flap	11	302.20	11
E919	Intracranial duraplasty (greater than 2 cm diameter), add to any intracranial procedure		161.40	
E920	Intraoperative electrophysiological monitoring and/or stimulation, add to any intracranial procedure		178.60	
E921	Repeat craniotomy (excluding N127, add to benefit for above surgery involving craniotomy)		144.20	
	Cranio-Cerebral Injuries			
U.V.C.	Non-operative care:		visit fees	
	Reduction of skull fracture:			
N139	Simple, depressed	7	250.70	7
N140	Compound	11	340.00	11
E912	— with repair of dural laceration, add		89.30	4
	Extracerebral haematoma and/or hygroma:			
N143	Drainage by burr hole(s) — unilateral	7	340.00	7
N144	Drainage and/or removal by craniotomy	11	535.80	11
	Cerebral Injury			
N148	Removal of intracerebral haematoma and/or debridement of traumatized brain (includes management of any skull fracture)	11	590.70	15

SURGICAL PROCEDURES

OPERATIONS ON THE NERVOUS SYSTEM

Code	BRAIN – Cont'd	Asst.	Surg. $	Anaes.
N149	Removal of foreign body from brain	11	590.70	15
N150	C.S.F. leak — intracranial repair (to include transsphenoidal approach)	11	714.35	15
N200	Decompressive craniectomy (frontal, sub-temporal)	11	412.10	11
Z803	Subdural tap(s) (I.O.P.) — unilateral		35.80	
Z814	Diagnostic burr hole(s) (I.O.P.) — uni or bilateral	7	178.60	7
	SKULL			
	Repair of skull defect:			
N161	Acrylic or metal cranioplasty	11	377.80	11
N201	Rib graft cranioplasty (defect less than 7.5 cm.)	11	573.50	15
N202	Replacement of bone flap	11	322.80	11
N203	Skull tumour, excision	11	250.70	11
	Craniosynostosis			
	Linear craniectomy:			
N206	one suture	11	288.50	11
N207	multiple sutures	11	377.80	15
	Morcellation procedure			
N162	one suture	11	288.50	11
N163	multiple sutures	11	377.80	15
	Lateral canthal advancement			
	Unilateral			
N164	— one surgeon	11	467.10	15
N165	— two surgeons — major portion of surgery	11	288.50	15
N166	— lesser portion of surgery		212.90	
	Bilateral			
N167	— one surgeon	11	607.90	15
N168	— two surgeons — major portion of surgery	11	377.80	15
N169	— lesser portion of surgery		267.90	
N208	Craniotomy for craniofacial repair	11	714.35	15
E922	With repair of frontonasal encephalocoele ..... add		144.20	
	ORBIT			
N211	Craniotomy plus removal of orbital tumour	11	748.70	15
N212	Craniotomy plus orbital decompression (roof of orbit with or without lateral wall)	11	700.60	15
N213	Craniotomy for decompression of optic nerve(s)	11	748.70	15
E901	— with operating microscope, add to N211, N213		144.20	
	PITUITARY			
N215	Hypophysectomy (other than for removal of tumour) — (any technique)	11	789.90	15
E901	— with operating microscope ..... add		144.20	

SURGICAL PROCEDURES

OPERATIONS ON THE NERVOUS SYSTEM

Code	PITUITARY – Cont'd	Asst.	Surg. $	Anaes.
	Excision of tumour			
N171	Transfrontal	11	824.25	15
E901	— with operating microscope add		144.20	
N172	Microscopic transphenoidal for macroadenoma	11	824.25	15
N173	Microscopic transphenoidal for microadenoma (less than 1 cm)	11	824.25	15
	CAROTID AND VERTEBRAL ARTERIES			
N220	Carotid endarterectomy (with or without bypass and/or patch graft)	7	501.40	10
N223	Vertebral endarterectomy	10	535.80	10
E923	Intraoperative cerebral blood flow determinations (with carotid endarterectomy, etc.), add to N220, Z808		89.30	
Z815	Temporal artery; biopsy, ligation or cryosurgery (I.O.P.)		72.10	4
Z808	Progressive carotid occlusion by Selverstone clamp (I.O.P.)	10	212.90	10
Z807	Removal of Selverstone clamp (I.O.P.)	10	178.60	10
	CSF SHUNTING PROCEDURES			
N230	Shunting procedures, all types except those otherwise specified below	11	267.90	11
N209	Ventriculo-atrial shunt	11	305.70	11
N210	Lumbo-peritoneal shunt (including laminectomy)	11	267.90	11
	Revision of CSF shunt — operative			
N245	Proximal end	7	178.60	7
N175	Distal end (all shunts except ventriculoatrial)	7	178.60	7
N176	Distal end — ventriculoatrial	7	212.90	7
Z801	Revision — non-operative (I.O.P.)		54.95	
N174	Conversion of shunt (e.g. ventriculoperitoneal to ventriculoatrial) — includes removal of existing shunt	7	267.90	7
N246	Removal of shunt — any type	7	123.60	7
N247	Ventriculo-cisternostomy (Torkildsen)	11	357.20	11
Z809	Insertion of CSF reservoir (Ommaya) including burr holes (I.O.P.)	11	161.40	11
N249	Third ventriculostomy	11	412.10	11
Z821	Injection of diagnostic or therapeutic agent into shunt apparatus (I.O.P.)		35.80	
	CRANIAL NERVES			
N258	Percutaneous coagulation of gasserian (trigeminal) ganglion or root — unilateral	11	233.50	11
N259	V — Decompression or rhizotomy (partial or complete) trigeminal nerve	11	322.80	11

SURGICAL PROCEDURES

OPERATIONS ON THE NERVOUS SYSTEM

Code	CRANIAL NERVES - Cont'd	Asst.	Surg. $	Anaes.
N265	VII — Differential section facial nerve for hemi-facial spasm (extra-cranial approach)	6	233.50	6
N266	Anastomosis hypoglossal or accessory to facial nerve	6	377.80	6
E901	with operating microscope add to N266, N267		144.20	
N267	Occipital and/or suboccipital craniectomy for compression, decompression or section of cranial nerves	11	645.70	11
N269	XI — Division of nerves to sternomastoid in neck	6	195.80	6
Z826	Inferior dental neurectomy (I.O.P.)	3	123.60	4
Z827	Infraorbital or supraorbital neurectomy (I.O.P.)	3	106.50	4
	PERIPHERAL NERVES			
	Brachial plexus exploration:			
N280	In posterior triangle (**not for treatment of cervical rib**)	6	302.20	6
N281	In axilla	6	391.50	6
N282	In posterior triangle and axilla	6	535.80	6
N283	Decompression by scalenotomy **alone**	6	106.50	6
N284	Decompression be excision of first rib **and/or cervical rib to include scalenotomy when required**	6	267.90	6
	Exploration and/or decompression of sciatic nerve			
N177	Subgluteal	6	267.90	6
N178	In thigh	6	195.80	6
N179	Subgluteal and in thigh	6	302.20	6
N290	Decompression median nerve at wrist (carpal tunnel syndrome)	3	106.50	4
N293	Decompression lateral femoral cutaneous nerve	4	106.50	4
N285	Exploration and/or decompression and/or transposition and/or neurolysis of major nerve (excluding sciatic and carpal tunnel)	4	144.20	4
N286	Removal of tumour major peripheral nerve	4	212.90	4
	Suture of major peripheral nerve			
N287	Epineural	4	233.50	4
N180	Fascicular	4	288.50	4
N183	Graft of minor nerve e.g. digital	3	89.30	4
	Graft of major peripheral nerve, with or without lengthening procedure			
N288	Epineural	4	391.50	4
N181	Fascicular (regardless of the number of strands per gap)	4	446.50	4
E925	Delayed repair (more than 4 weeks) add		89.30	
E931	Repeat surgery on peripheral nerve (more than four weeks after original surgery), add		106.50	

SURGICAL PROCEDURES

OPERATIONS ON THE NERVOUS SYSTEM

Code	PERIPHERAL NERVES - Cont'd	Asst.	Surg. $	Anaes.
N289	Suture or decompression of small peripheral nerve (digital)	3	89.30	4
E906	— with operating microscope, — add to peripheral nerve repair as specified (N285, N286, N287, N180, N288, N181, N289)		72.10	
N294	Division, obturator nerves	6	123.60	6
Z828	Biopsy and/or avulsion peripheral nerve I.O.P.	3	106.50	4
N295	Morton's Neuroma, excision	4	72.10	4
Z811	Excision of glomus tumour (I.O.P.)		68.70	4
Z136	Excision of neuroma — single, subcutaneous (I.O.P.)		68.70	4
N296	Denervation of gastrocnemius	4	123.60	4
Z816	Implantation of electrode for peripheral nerve stimulation (I.O.P.)	3	161.40	4

AUTONOMIC NERVOUS SYSTEM

Code		Asst.	Surg. $	Anaes.
	Sympathectomy: — unilateral			
N300	Cervical	6	233.50	6
N301	Cervicodorsal	10	391.50	10
N303	— thoracic approach	9	288.50	13
N304	Lumbar	6	195.80	6

SPINAL CORD AND NERVE ROOTS

Code		Asst.	Surg. $	Anaes.
Note:	For operations on the spinal cord and nerve roots, the basic assistants' and anaesthetists' fees will depend on the surgical approach except if a basic fee is listed.			
N315	Cervical or thoracic	8		10
N316	Lumbar	7		8
	Tumours: (claim must state location)			
N317	Extradural partial or total removal		590.70	
	Removal by anterior or anterolateral cervical or thoracic approach			
N314	— one surgeon		789.90	
M137	— two surgeons — thoracotomy		257.60	
N313	— excision		680.00	
N318	Intradural (extramedullary) partial or total removal		748.70	
E914	— three segments or more, add		106.50	

SURGICAL PROCEDURES

OPERATIONS ON THE NERVOUS SYSTEM

Code	SPINAL CORD AND NERVE ROOTS – Cont'd	Asst.	Surg.	Anaes.
			$	
	Intramedullary:			
N319	— Biopsy and/or decompression		680.00	9
N320	— Removal		858.60	12
E914	— three segments or more, add		106.50	
E901	— with operating microscope (applies to intradural or intramedullary tumours) add		144.20	
	A.V. malformation of cord			
N321	Excision or operative obliteration; with or without evacuation of haematoma		858.60	12
E914	Three segments or more add		106.50	
E901	— with operating microscope add		144.20	
Z800	Myeloscopy (I.O.P.)		144.20	
	Decompressive Procedures:			
	1. Applicable to all operative procedures for decompression of the spinal cord and/or nerve roots, whether traumatic or non-traumatic, with the exception of tumours and arterio-venous malformations and others separately listed.			
	Posterior Spinal Decompressive Procedures			
R451	Cervical hemilaminectomy for disc disease with or without foraminotomy	6	394.95	10
R457	Lumbar hemilaminectomy for disc disease **including removal of** soft disc, osteophyte	6	288.50	8
N185	—posterior **laminectomy** one or two levels, **cervical, thoracic, lumber**		412.10	
N337	**Repeat posterior decompression or reopening of posterior decompression more than six months after original procedure, includes foraminotomy discectomy or neurolysis**	8	446.50	10
E565	multiple levels to **R451, R457** per additional level		54.95	
E566	—bilateral to **R451, R457** add		54.95	
E914	**Laminectomy extending over 3 or more laminae, to N185, N337, add**		106.50	
E915	**Foraminotomy, to R457, N185 per foramen decompressed, add**		54.95	
	Anterior, Anterolateral or Posterolateral Spinal Decompressive Procedures			
R447	**Simple anterior cervical discectomy**	8	250.70	10
R452	**Simple anterior lumbar discectomy**	6	357.20	10
N182	**Anterior cervical spinal cord or nerve root decompression, including removal of disc or vertebral body, single disc level**		412.10	

SURGICAL PROCEDURES

OPERATIONS ON THE NERVOUS SYSTEM

Code	SPINAL CORD AND NERVE ROOTS – Cont'd	Asst.	Surg. $	Anaes.
N186	Anterolateral or posterolateral **decompression, lumbar or thoracic spine, single disc level**		748.70	13
Note:	**For thoracotomy or laparotomy by separate surgeon use M137 (page 160) S312 (page 187)**			
E928	— each additional **disc level decompressed, to R447, R452, N182, N186** add		178.60	
E929	**Anterior cervical** interbody fusion (by same surgeon) **to R447, N182 per disc level** add		54.95	
	Fusion by same surgeon, to any procedure except anterior cervical interbody fusion			
E567	— one level add		178.60	
E568	— two or more levels add		233.50	
	Fusion by different surgeon			
R493	— one level		212.90	
R494	— two or more levels		250.70	
E574	**Repeat** fusion, to any **fusion** add		161.40	
E548	**— with instrumentation** add		106.50	
	Dural opening and repair			
E907	Opening of dura (associated with any decompressive procedure) add		106.50	
E926	Spinal duraplasty (applies to any spinal procedure)add		161.40	
	Other Laminectomies (uni or bilateral):			
N336	Laminectomy for intradural neurolysis or unusual lesions (e.g. diastematomyelia, tethered conus, intramedullary haematoma, etc.) — uni or bilateral		535.80	
E914	Laminectomy extending over 3 segments or more **(applies to thethered conus, diastematomyelia extradural, intradural or intramedullary tumour, AVM. or other decompressive laminectomy** add		106.50	
E901	**— with operating microscope** add		144.20	
	Re-opening of laminectomy			
N323	— for postoperative haematoma or infection		250.70	
N192	**Re-opening of laminectomy** for repair of C.S.F. leak		357.20	
	Spinal Fractures			
Z236	Skull calipers (IOP)		34.30	
Z241	Halo traction (IOP)		54.95	
Z246	Reapplication of Halo traction (IOP)		34.30	
E562	Counter traction pins or vest — add		72.10	
F103	Closed Reduction	5	127.10	5
F105	Open Reduction, posterior approach	5	212.90	5

SURGICAL PROCEDURES

OPERATIONS ON THE NERVOUS SYSTEM

Code	SPINAL CORD AND NERVE ROOTS – Cont'd	Asst.	Surg. $	Anaes.
F107	anterior approach	7	250.70	10
E913	With spinal cord injury, add		106.50	
E927	With irrigation, includes opening of dura, to fractures when combined with decompressive procedures . add		212.90	
E567	Fusion by same surgeon, one level . add		178.60	
E568	**two or more** levels . add		233.50	
E929	— anterior cervical interbody fusion per level . add		54.95	
R493	Fusion by different surgeon, one level . add		212.90	
R494	**two or more** levels . add		250.70	
E924	— anterior cervical interbody fusion . add		82.40	
E548	With instrumentation . add		106.50	
	Syringomyelia:			
N193	Posterior fossa craniectomy and plugging of obex (to include decompression of Arnold Chiari malformation if present)		680.00	15
E919	Intracranial duraplasty (greater than 2 cm. diameter), add to any intracranial procedure		161.40	
N194	Syringo subarachnoid shunt		535.80	
N195	Terminal ventriculostomy		535.80	
N196	Syringopleural shunt		625.10	
E901	— with operating microscope (add to N193 to N196)		144.20	
	Ablative and Stimulation Procedures:			
N329	Percutaneous cordotomy or tractotomy		267.90	
N330	Open myelotomy for lesion (e.g. Tractotomy, midline commissurotomy, Bischoff's longitudinal myelotomy, etc.) — uni or bilateral		645.70	
N341	Medullary spinal trigeminal tractotomy		680.00	
E901	— with operating microscope, . add		144.20	
N326	Percutaneous diagnostic stimulation of spinal cord		233.50	
N324	Implantation of spinal cord stimulating electrode by laminectomy		377.80	
Z822	Implantation or revision of stimulator pack for chronic stimulation (I.O.P.)		178.60	

SURGICAL PROCEDURES

OPERATIONS ON THE NERVOUS SYSTEM

Code	SPINAL CORD AND NERVE ROOTS – Cont'd	Asst.	Surg.	Anaes.
			$	
N332	Removal of stimulation system		144.20	
Note:	N324, N326, Z822, N332 for "multiple sclerosis" are not a benefit of O.H.I.P. except for relief of intractable pain.			
N331	Spinal intradural anterior and/or posterior rhizotomy, uni or bilateral, any number of roots		429.30	
N333	Dorsal root entry zone lesions for pain relief (any number of levels) — includes use of operating microscope		680.00	
	Percutaneous vertebral facet denervation or intercostal neurectomy (I.O.P.)			
Z810	— first level		54.95	4
E909	— additional levels (to a maximum of 4 additional levels) — each		17.90	
	Percutaneous radiofrequency posterior rhizotomy — for pain or spasticity			
N340	— one or two roots		178.60	
E910	— third to sixth root, each		35.80	
Z817	Lumbar subarachnoid drainage of C.S.F. — (chronic), (I.O.P.)		54.95	
	Meningocoele and Meningomyelocoele			
N334	Repair of meningocoele		288.50	
	Repair of meningomyelocoele			
N335	— one surgeon		391.50	
N338	— two surgeons — neurosurgeon		288.50	
N339	— reconstructive surgeon		233.50	
N197	Repair of lipomeningocoele (to include release of tethered spinal cord)		556.40	
E901	— with operating microscope, add (to N197, N335 or N338)		144.20	
N198	Repair of anterior sacral meningocoele posterior approach (to include release of tethered spinal cord)		573.50	
N199	Repair of intraspinal meningocoele (extradural cyst)		573.50	

SURGICAL PROCEDURES

OPERATIONS ON ORGANS OF SPECIAL SENSES

Code	OPERATIONS ON THE EYE	Asst.	Surg. $	Anaes.
Z850	Examination and unlisted minor procedures under general anaesthesia (I.O.P.)		44.60	4
	EYEBALL			
	Excision			
E102	Enucleation	4	178.90	4
E103	Evisceration	4	179.90	4
E108	Enucleation, donor eye, post-mortem (one or both)		89.30	
	Repair			
E104	Removal of intraocular foreign body	4	254.10	6
E105	Non-magnetic — posterior segment	4	288.50	6
	Penetrating wound			
E106	with prolapse of intraocular tissue	4	178.90	6
E107	without prolapse of intraocular tissue	4	144.20	6
	CORNEA			
	Incision			
Z851	Paracentesis (I.O.P.)		35.80	4
	Removal embedded foreign body (I.O.P.)			
Z847	local anaesthetic — one foreign body		17.90	
Z848	— two or more foreign bodies (see Preamble, Part B, paragraph 22)		I.C.	
Z852	general anaesthetic		35.80	4
U.V.C.	Corneal scraping		visit fees	
	Chelation of band keratopathy with EDTA (I.O.P.)			
Z849	local anaesthetic		17.90	
Z863	general anaesthetic		35.80	4
	Excision			
E206	Pterygium — simple (unilateral)		64.40	4
E205	— with partial keratectomy	4	164.85	4
E207	— with lamellar graft	4	288.50	8
E117	Keratectomy	4	164.85	4
E118	Excision of dermoid **with partial keratectomy**		164.85	4
E119	**— with lamellar graft**	4	288.50	8
	Cauterization of ulcer (I.O.P.)			
Z871	— local anaesthetic		17.90	
Z853	— general anaesthetic		35.80	4

SURGICAL PROCEDURES

OPERATIONS ON ORGANS OF SPECIAL SENSES

Code		Asst.	Surg. $	Anaes.
	CORNEA - Cont'd			
	Replacement			
	Corneal transplant			
E121	penetrating	4	377.80	8
E951	with artificial prosthesis, add		35.80	
E122	lamellar	4	288.50	8
E123	Division of iris to cornea		109.90	4
	SCLERA			
	Incision			
E127	Sclerotomy, posterior		89.40	4
E128	Anterior chamber — open evacuation of clot	4	212.90	6
	IRIS AND CILIARY BODY			
E131	**Laser iridotomy**	4	164.60	4
E134	**Laser angle surgery**		199.20	
E130	Iridectomy — surgical	4	193.20	4
E132	Glaucoma **filtering** procedures	4	212.90	6
Note:	Includes iridectomy, iridenclesis, corneoscleral trephine, cyclodialysis, sclerectomy or goniotomy.			
E133	Extraocular glaucoma procedures	4	125.20	4
E135	**Ciliary body re-attachment**	4	343.40	8
Note:	Includes cyclodiathermy, cyclocryopexy.			
	CRYSTALLINE LENS			
	Incision			
	Needling (discission)			
E137	— primary or subsequent		110.90	5
E139	Capsulotomy	4	110.90	4
	Excision			
	Cataract (includes iridectomy and retrobulbar injection when administered by surgeon.)			
E140	— all types of by any procedure	4	288.50	8
E141	— dislocated lens **extraction**	4	343.40	6
E950	— insertion of intraocular lens, extra		89.30	
E138	**Fixation** of intraocular lens (McCannell suture procedure)	4	193.20	6
E143	— excision of secondary membrane with corneal section following cataract extraction	4	178.90	6
E144	Removal of intraocular lens	4	178.90	6
E145	Repositioning, **surgical,** of dislocated intraocular lens		89.40	4
E146	Insertion of secondary intraocular lens	4	199.20	8

SURGICAL PROCEDURES

OPERATIONS ON ORGANS OF SPECIAL SENSES

Code		Asst.	Surg. $	Anaes.
	VITREOUS			
E147	Vitreous transplant, implant or anterior vitrectomy	4	178.90	6
E148	Vitrectomy by infusion suction cutter technique (e.g. Peyman)	4	412.10	8
E149	Vitreous aspiration, posterior with needle for culture and/or injection of medication, with or without cryopexy	4	125.20	5
	RETINA			
E151	Re-attachment of retina and choroid by diathermy, photocoagulation or cryopexy as an initial procedure	6	203.90	6
E152	Scleral resection or buckling procedure — with or without diathermy, photocoagulation or cryopexy, **primary or subsequent procedure**	6	377.80	6
E153	Secondary operation following unsuccessful operation or fresh detachment in the same eye by a different surgeon with or without diathermy, photocoagulation or cryopexy	6	432.70	6
E161	Removal of scleral implant		109.90	4
E154	Photocoagulation (xenon, argon laser, etc.) — one eye		123.60	6
E155	Cryopexy — extra-ocular or sub-conjunctival — one eye		123.60	6
	EXTRAOCULAR MUSCLES			
	Repair			
	Strabismus procedures			
E159	— one or two muscles, one or both eyes	3	178.90	5
E162	— three or more muscles, one or both eyes	3	214.65	5
E949	**—for adjustable suture, add**		35.80	
E952	Repeat strabismus procedure (more than two previous repairs) by different surgeon, add		35.80	
	ORBIT			
	Incision			
E164	Drainage of abscess		143.10	6
	Excision			
	Tumour or foreign body			
E166	— anterior route	4	178.90	6
E167	— posterior exposure	4	322.80	6
E171	Exenteration, with or without major plastic repair	4	254.10	6
E172	Biopsy (anterior)		109.90	4

SURGICAL PROCEDURES

OPERATIONS ON ORGANS OF SPECIAL SENSES

Code	ORBIT - Cont'd	Asst.	Surg. $	Anaes.
E168	**Biopsy (posterior exposure)**		178.90	4
E165	Lateral orbitotomy (Kronlein)	3	288.50	6
E169	**Decompression — two walls**	4	288.50	6
E170	**— three walls**	4	322.80	6
	Repair — for codes E173, E174, E175 see page 139.			
	EYELIDS			
	Incision			
	Drainage of abscess (I.O.P.)			
Z854	local anaesthetic		17.90	
Z855	general anaesthetic		44.60	4
	Excision			
	Chalazion — single or multiple (I.O.P.)			
Z874	local anaesthetic		17.90	
Z856	general anaesthetic		44.60	4
Z857	Epilation by hyfrecator, electrolysis (I.O.P.)		17.90	4
Z858	**— by cryopexy**		44.60	4
	Verruca, papilloma, keratosis, etc. — see pages 115 & 116			
	Unlisted Plastic Procedures			
E177	Very Minor (e.g. skin only)		65.10	4
E186	Minor (e.g. muscle repair)	3	99.45	4
E187	Intermediate (e.g. full thickness wedge resection)	4	183.90	4
E188	Major (e.g. translation of lateral flap)	4	275.50	5
E189	Extensive major (e.g. pedicle flap)	4	402.10	6

Note: Descriptive details of procedure (eg: operative report) should be submitted with claims for codes E177, E186-E189 — Refer to Surgical Preamble, paragraphs (16), (17).

Code	Procedure	Asst.	Surg.	Anaes.
	Suture			
E190	Tarsorrhaphy		75.55	4
E191	Double adhesion		109.90	4
	Repair			
E192	Ptosis	4	214.65	4
E193	repeat or second repair	4	268.30	6
E194	Distichiasis — unilateral	4	164.85	4
E195	Trichiasis, repair by tarsal transplantation	4	164.85	4
E196	Entropion, other than Zeigler puncture	4	178.90	4

SURGICAL PROCEDURES

OPERATIONS ON ORGANS OF SPECIAL SENSES

Code		Asst.	Surg.	Anaes.
	EYELIDS - Cont'd		$	
E945	**— repeat by second surgeon, add**		35.80	
	— with skin graft, see page 119			
E948	**—with mucous membrane graft, add**		75.55	
E197	Ectropion, other than Zeigler puncture	4	178.90	4
E945	**— repeat by second surgeon, add**		35.80	
	— with skin graft see page 119			
Z860	Zeigler punctures (for entropion/ectropion) (I.O.P.)		17.90	4
E199	Laceration, full thickness,		89.40	4
E198	**— including lid margin**		178.90	4
	Blepharoplasty (O.H.I.P. authorization necessary.)			
E200	— simple excision of skin of one lid		57.20	4
E201	— simple excision and repair of orbital septum-one lid	4	110.90	4
E202	— simple excision and repair of orbital septum and lid fold reconstruction — one lid	4	178.90	4
E211	Lid lengthening procedure	4	123.60	4
E953	— with scleral graft, add		54.95	
	CONJUNCTIVA			
U.V.C.	Removal of foreign body		visit fees	
	Excision			
E208	Peritomy (Gunderson conjunctival flap)		75.10	4
Z861	Biopsy (I.O.P.)		17.90	4
	Repair			
E210	**Excision and repair of conjunctival lesion**		54.95	4
E948	**Mucous membrane graft**		75.55	4
	LACRIMAL TRACT			
	Incision (I.O.P.)			
Z862	Dacryocystotomy — general anaesthetic		35.80	4
Z917	Three "Snip" punctum procedure		44.60	4
	Excision			
E215	Dacryocystectomy	4	178.90	4
	Repair			
	Lacerated canaliculus			
E216	immediate repair	4	144.20	4
E217	delayed repair	4	233.50	5
E218	Dacryocystorhinostomy	5	288.50	5

Code	LACRIMAL TRACT – Cont'd	Asst.	Surg. $	Anaes.
E954	— with lacrimal bypass procedure (e.g. Lester Jones or canalicular reconstruction), add		54.95	
E219	Lacrimal bypass procedure (e.g. Lester Jones) — when sole procedure (both stages)		125.80	4
E220	**Lateral canthal tenodesis**		178.90	4
	Manipulation (I.O.P.)			
Z901	Irrigation of nasolacrimal system — unilateral or bilateral		13.70	
	Probing and dilation of duct, **initial or repeat**			
Z902	Local anaesthetic, unilateral		13.70	
Z864	General anaesthetic — unilateral or bilateral		54.95	4
Z865	— with insertion of inlying tube or filament		109.90	4
Z918	**Re-insertion of Lester Jones tube**		35.80	

OPERATIONS ON THE EAR

Note: When debridement of ears under microscopy is carried out for removal of cerumen or for access purposes only, no charge should be made for the debridement. If debridement of ears under microscopy is carried out because of pathology, a claim may be made for this service.

EXTERNAL EAR

Code		Asst.	Surg.	Anaes.
	Endoscopy			
U.V.C.	Removal of foreign body — simple		visit fees	
Z866	— complicated — general anaesthetic (I.O.P.)		35.80	4
E302	— **requiring** post auricular **or endural incisions**		143.10	4
E303	— from middle ear space		143.10	4
Z906	Removal of drainage tube(s) — general anaesthetic (I.O.P.)		25.00	4
Note:	Z906 may not be claimed with Z914.			
Z907	Debridement of **mastoid cavity** and/or repair of small perforation under microscopy (I.O.P.)		17.90	
Z908	— under general anaesthetic (I.O.P.)		30.80	4
Note:	Z907, Z908, not for removal of cerumen for "access only".			
	Incision			
Z909	Biopsy ear canal (I.O.P.)		17.90	
Z846	— general anaesthetic (if sole procedure performed)		30.80	4
E305	Limited incision for perichondritis, removal of cartilage and drainage		95.90	4
E306	Radical surgery for perichondritis		196.80	5

SURGICAL PROCEDURES

OPERATIONS ON ORGANS OF SPECIAL SENSES

Code	**EXTERNAL EAR - Cont'd**	Asst.	Surg. $	Anaes.
	Excision			
Z904	Local excision, polyp — office (I.O.P.)		17.90	
Z905	— hospital (I.O.P.)		28.60	4
E300	**Resection of pinna — with primary closure**		100.20	4
E301	**— with local flap**		128.80	4
E311	Exostosis, simple endomeatal surgery and removal and drilling out of exostosis		95.90	4
E312	— with multiple removal with necessary grafting		147.40	4
E313	— post auricular approach		203.90	5
Z903	Pre-auricular sinus (I.O.P.)		23.25	4
E309	— **requiring general anaesthetic**		143.10	5
	Repair			
	Congenital defects			
E307	external — minor	5	135.90	5
E308	— major	5	211.10	5
E310	— otoplasty for correction of outstanding ears — (patients under 18 years of age) — unilateral	5	161.00	5
E304	**Total ear reconstruction with cartilage graft — (Brent technique)**	4	429.30	9
Note:	E304, E307, E308 — Descriptive details of procedure (eg: operative report) should be submitted with claims (see Surgical Preamble, paragraph 17). E310 — this procedure is not a benefit of OHIP for patients 18 years of age or older.			
E314	Meatoplasty **or canalplasty for** congenital **malformation**	5	143.10	5
E955	— with grafting of **canal** add		143.10	1
E956	— with tympanoplasty **and/or ossiculoplasty and/or** mastoidectomy, add		282.60	2
	MIDDLE EAR			
	Introduction (I.O.P.)			
	Eustachian			
Z910	Unilateral — local anaesthetic		4.30	
Z911	Unilateral or bilateral — general anaesthetic		25.00	4
	Incision (I.O.P.)			
	Myringotomy to include aspiration when indicated			
Z912	**Office procedure — unilateral**		12.20	
Z913	**Hospital procedure** — with or without operating microscope, unilateral		29.50	4

SURGICAL PROCEDURES

OPERATIONS ON ORGANS OF SPECIAL SENSES

Code	MIDDLE EAR - Cont'd	Asst.	Surg. $	Anaes.
Z914	**Hospital or office procedure** — with insertion of ventilation tube using operating microscope, unilateral		55.45	4
	Excision			
	Mastoidectomy			
E320	Cortical mastoidectomy,	4	221.80	6
E322	Modified or radical mastoidectomy	4	354.20	7
E315	Revision mastoidectomy with revision of middle ear	4	382.80	7
E946	**— with mastoid cavity obliteration (E320, E322 or E315), add**		71.55	
E959	— with meatoplasty and/or **canalplasty,** add		71.55	
	Repair			
E323	Myringoplasty		147.40	5
E336	Tympanoplasty — Type 1 **(myringoplasty with exploration of middle ear)**		221.80	7
E337	**—with ossiculoplasty**		318.40	7
E957	— with mastoidectomy, add		95.90	
E959	— with meatoplasty and/or **canalplasty,** add		71.55	
E333	**Ossiculoplasty**	4	286.20	7
E325	Facial nerve decompression	4	465.10	9
E326	Facial nerve graft	4	536.60	9
E327	Closure of mastoid fistula	4	176.70	4
E328	Tympanotomy		147.40	4
E329	**Tympanic neurectomy**		261.15	6
E316	Tympanotomy with round or oval window fistula repair		214.65	6
E324	Tympanotomy with insertion of "permanent" ventilation tube		184.60	4
	INNER EAR			
	Incision			
	Labyrinthotomy or Labyrinthectomy			
E332	**(including** Fick procedure)		386.40	7
	Repair			
E334	Stapes mobilization, unilateral		261.15	6
E335	Stapedectomy with prosthesis		386.40	6
E338	**Singular nerve section**	4	465.10	9
E339	**Endolymphatic shunt or sac decompression**	4	429.30	9

April 1, 1983

Ontario Health Insurance Plan

Schedule of Benefits

LABORATORY MEDICINE

Ontario

Ministry of
Health

LABORATORY MEDICINE

Note: Claims for laboratory services, when referred by a Dentist, Osteopath, Chiropodist or Chiropractor are not insured services.

PREAMBLE:

1. The patient documentation and specimen handling benefit is applicable to all patients, except for those items listed under the anatomical pathology, histology and cytology sections. The items in this section have been left at a sufficient level to cover administrative costs. This benefit is not applicable to referred-in samples, since the collecting laboratory will already have claimed the patient documentation and specimen collection benefit.
2. The biochemistry section has been condensed so that one listing refers to a procedure for any of amniotic fluid (A), blood (B), C.S.F. (C), faeces (F), gastrointestinal fluid (G), urine (U). Exceptions are indicated by B, U, etc., following the test name. Other specimens will be considered on an I.C. basis.
3. A number of tests are listed in different sections of the schedule, i.e. when more than one method of performing the test is available, e.g. Aminophylline is listed under both Biochemistry and Radioassays. Assays of ligand type other than radioisotopic are listed under Biochemistry.
4. Blood glucose by the dipstick method may be claimed only when assessed by an appropriate instrument such as a reflectance meter. It should not be claimed when used only as a check on the fasting blood sample of a glucose tolerance test. The blood glucose of the fasting sample in a glucose tolerance test is allowable only once even if assessed by two methods.

Note: The standard glucose tolerance test for diagnosis of diabetes mellitus consists of 5 blood specimens taken at 0, 30, 60, 90 and 120 minutes following oral administration of 75g. of glucose. In pregnancy, 4 specimens only are to be taken at 0, 60, 120 and 180 minutes. (L104 and L103).

5. Code L418 or L417 may not be claimed by a physician in addition to claim(s) for any treatment or assessment. However, Code G481 (see page 99 of the 1983 OHIP Schedule of Benefits) may be claimed by a physician if a haemoglobin screen (any method or instrument) is carried out in the course of an office or home visit. Urinalysis (G009, G010) may be claimed with or without an associated visit to a physician's office (except for screening and urinalyses which are not medically necessary).
6. When a screening culture method (e.g. Agar spoon) is used on a urine sample, L641 refers to a culture technique and does not apply to those kits using the nitrite test only. Where a significant growth is obtained and followed up by definitive identification methods, L633 or L634 only should be claimed. The benefits for L633 and L634 include any necessary microscopic examination of the urine.
7. The Physician assumes responsibility for all cytology smears and the professional benefits (L804 to L815 inclusive) are weighted averages of the professional component. These benefits, therefore, are applicable in each case whether or not all slides are examined by the physician.
8. Only those tests which are requested are to be claimed with the following exceptions. It is intended that if the test results yield abnormal findings or information which would be incomplete, insufficient or meaningless to the referring physician, the medical director of

a laboratory may add further appropriate tests and claim for them with the knowledge he may have to substantiate their justification.

9. A test must be completed in accordance with the pertinent Schedule listing in order to charge for it. The verbatim listing is intended as the definitive benefit for that test alone, unless otherwise specified e.g. isoenzymes do not include total enzyme estimations: creatine does include creatinine (as specified). Notwithstanding the foregoing and recognizing that it is impossible to list all variations in techniques of all listed tests, when there is a modification of the usual technique, the listing most closely approximating it should be used.

10. This schedule, with the exception of L036, lists actual procedures performed. No claim shall be made for calculated values made and reported, or for control tests or repeat tests on the same patient sample.

11. The benefit for seminal fluid examination (complete) is to include sperm count, volume estimation, motility and morphology and viscosity. The benefit for seminal fluid examination carried out post-vasectomy is not to be claimed by the operating surgeon unless the patient requires more than one office visit post-operatively.

12. Creatinine is a justifiable addition in the case of tests on 24-hour urine samples, where it is necessary to assess the sample as a complete 24-hour collection. However, if several tests (e.g. steroids) are done on a single such sample, only one creatinine should be claimed for that sample. In those estimations where the test result is expressed in terms of creatinine excretion the performance of a creatinine is mandatory and may be claimed.

13. It is recognized that in requests for a serologic titre, if a screening test is used and would suffice, the lesser benefit for the screening test should be claimed. If positive and followed by a serial titration, both the screening and titre fees may be claimed. If the titration is a micro technique using plates, it is the equivalent of a tube titre, the wells being miniature tubes.

14. When a test for trichomonas identification (any method) is carried out in association with L625 or L627, code L653 may be claimed in addition. L653 also may be claimed when Wet Preparation is used for direct examination of a fresh specimen for vegetative amoebae or similar parasites. However, the wet preparation used in the faeces concentration technique for parasites and ova is included in L650.
    The conditions set down in paragraph 8 of this preamble must be adhered to.

15. It is recognized that in all laboratory tests there is a professional component.

16. The maximum number of units which may be claimed for any combination of L418 (Hemoglobin), L417 (Hematocrit); L399 (WBC Count) and L397 (RBC Count) is 11 LMS units per patient per day, whether automated, semi-automated or manual methods are used. L700 is not included in this total and may be claimed separately, if appropriate. Laboratories using multichannel equipment should use individual codes as described above.

17. The maximum number of units which may be claimed for any combination of the tests represented by the following codes will be 40 LMS units per patient per day:

    L005
    L030
    L045
    L053
    L061
    L067
    L111
    L191
    L194
    L204
    L208
    L222
    L223
    L225
    L226
    L251
    L252

    This maximum of 40 units applies on a per patient basis, regardless of the number of specimens submitted and regardless of the number of laboratories involved in performing the individual tests. Code L700 is not included in this maximum and should be claimed separately, if appropriate.

18. The maximum number of units which may be claimed for any combination of chemical analyses performed on a single sample by means of an automated chemical analyzer with simultaneously functioning channels is 18 LMS units (L225).

19. The definitions and guidelines in this paragraph apply to the Blood Bank section of Laboratory Medicine:
    (a) L471 Antibody Identification — incomplete antibodies. A panel of any number of cells regardless of suspending media or technique used. Preparation of eluate and/or antibody absorption is included.
    (b) L472 Antibody Identification — complete antibodies. A panel of any number of cells for the identification of complete antibodies by direct agglutination.
    (c) L473 Parallel Titration — to be used when two sequential patient serum specimens are tested to detect a change in antibody titre. Includes a repeat antibody identification on the current sample.
    (d) L490 Blood Group — ABO and $Rh_o(D)$. The subgroups of A and RhD^u are included where indicated. A direct AHGT is also included in L490, therefore, L495 may not be charged on the same patient when this code is claimed.
    (e) L492 Crossmatch. When an initial crossmatch is requested the appropriate claim is for L490 x 1, L482 x 1 plus L492 for each unit ordered. L490 and L482 may not be claimed more than once on the same day of service. L490 and L493 may not be claimed when these procedures are carried out as a confirmatory test on the units of blood to be transfused.
    (f) L493. This listing includes L490 (see (d), above) and Rh genotype to include the antigens C, D, E, c, e, and D^u when indicated. Any other antigen is to be claimed under L494.
    (g) L494 Blood Group per antigen. Antigens stated in L493 and L490 are excluded from this listing.
    (h) L495 Direct AHGT. This listing may be claimed when ordered as a single procedure or in addition to L482 when the latter is requested as a single procedure. L495 may not be claimed when L490 or L493 is claimed with L482 on the same patient on the same visit.

20. Antibiotic sensitivities should not be done routinely, but only when, by reason of its identification and/or its concentration, the isolated organism has a high probability of being pathogenic. **L621 applies to all routine antibiotic sensitivity testing regardless of the method used and including M.I.C. determination by manual kit or automated methodologies.**

21. The use of Nickersons Medium as a screening test for yeast is not a benefit.

22. The carcinoembryonic antigen test (CEA) L690 is not to be used as a general cancer screen. It is to be used only for following established malignancies.

23. This preamble is intended to apply to everyone using codes L700 and L001 to L731 and codes L800 to L837.

LABORATORY

L.M.S. UNITS	O.H.I.P FEE	L.M.S. UNITS	O.H.I.P. FEE
	$		$
1	0.45	41	18.45
2	0.90	42	18.90
3	1.35	43	19.35
4	1.80	44	19.80
5	2.25	45	20.25
6	2.70	46	20.70
7	3.15	47	21.15
8	3.60	48	21.60
9	4.05	49	22.05
10	4.50	50	22.50
11	4.95	51	22.95
12	5.40	52	23.40
13	5.85	53	23.85
14	6.30	54	24.30
15	6.75	55	24.75
16	7.20	56	25.20
17	7.65	57	25.65
18	8.10	58	26.10
19	8.55	59	26.55
20	9.00	60	27.00
21	9.45	61	27.45
22	9.90	62	27.90
23	10.35	63	28.35
24	10.80	64	28.80
25	11.25	65	29.25
26	11.70	66	29.70
27	12.15	67	30.15
28	12.60	68	30.60
29	13.05	69	31.05
30	13.50	70	31.50
31	13.95	71	31.95
32	14.40	72	32.40
33	14.85	73	32.85
34	15.30	74	33.30
35	15.75	75	33.75
36	16.20	76	34.20
37	16.65	77	34.65
38	17.10	78	35.10
39	17.55	79	35.55
40	18.00	80	36.00

LABORATORY MEDICINE

24. **Fees for laboratory medicine testing are not refundable (in whole or in part) to the referring physician or referring laboratory by the laboratory performing the tests.**
25. The benefits for patient documentation and specimen collection and each test are calculated by multiplying the individual L.M.S. Unit values by .45¢.
26. Laboratory tests on specimens sent outside Ontario are not a benefit of the Plan.
27. Effective January 1, 1983, **Secondary** Laboratories receiving specimens for additional (secondary) tests from another Laboratory that normally would be claimed as L319 or L500 should be claimed as L919 or L900 respectively.

Code		**LMS Units**
L700	PATIENT DOCUMENTATION AND SPECIMEN COLLECTION BENEFIT	7

L700 may only be claimed with an "L" code other than L701 to L724 and L800 to L829.

1. Limited to 1 per patient, per day.
2. Not allowed to the recipient of a referred sample from another laboratory.
3. Not allowed to the attending physician.
4. Not applicable to a patient visit solely to receive instructions or collection containers.
5. When multiple tests are ordered for the same patient for the same day, only one L700 may be claimed even though all specimens may not be available on any one day.
6. Not applicable to items under anatomical pathology, histology and cytology section.
(Fee Codes L701 to L724 inclusive).

BIOCHEMISTRY

(Applicable to all specimens except as denoted by B-blood, U-urine, F-feces, C-CSF, A-amniotic fluid).

L059	Acetaminophen	25
L001	Acetone, Qualitative (Ketones dipstick)	3
L002	Acetone, Quantitative	35
L003	Addis count — U	32
L004	Albumin, Qualitative	3
L005	Albumin, Quantitative (excluded if globulin and/or protein electrophoresis done)	10
L006	Alcohol, Ethyl-Quantitative	43
L007	Alcohols, Qualitative	25
L008	Alcohols, Fractionation and Quantification	45
L009	Aldolase	30
L010	Aldosterone	120
L011	Amino Acids — one way chromatography — B. U	15
L012	Amino Acids — two way chromatography — U	30

LABORATORY MEDICINE

BIOCHEMISTRY – Cont'd

Code		LMS Units
L013	Amino Acids, Fractionation and Quantitation	200
L014	Amino Acid Nitrogen	33
L071	Aminoglycosides (e.g. gentamicin, tobramycin)	40
L020	Aminophylline, Quantitative (theophylline)	40
L015	Ammonia	39
L016	Amniotic Fluid Scan	20
L017	Amniotic Fluid L/S Ratio	50
L018	Amylase	22
L021	Androstenedione	75
L019	Ascorbic Acid	25
L025	Barbiturates, Qualitative	25
L026	Barbiturates, Quantitative	35
L027	Barbiturates, Fractionation and Quantification	60
L028	Bile Microscopy	4
L029	Bilirubin, Qualitative — F	3
L030	Bilirubin, total	10
L031	Bilirubin, conjugated	10
	Blood gasses (see listings on pg. L8)	
L037	Blood Volume — excluding injection of dye	20
L038	Bromides	15
L039	Bromosulphthalein (BSP) excluding injection of dye	14
L045	Calcium	10
L046	Calcium Ionized	20
L047	Calculus analysis — chemical, Qualitative	15
L048	Calculus analysis, Qualitative and Quantitative	25
L073	Cannabinoid	35
L040	Carbamazepine, Quantitative	35
L049	Carotene	16
L050	Catecholamines, total	60
L051	Catecholamines, fractionated	80
L052	Ceruloplasmin	19
L041	Chlordiazepoxide, Quantitative	40
L053	Chloride	6
L054	Chloride (sweat)	33
L055	Cholesterol, total — not to be charged with L156	14
L056	Cholesterol, ester — not to be charged with L156	14
L057	Cholinesterase — pseudo or true	30
L058	Cholinesterase Genotyping (includes Pseudo, Dibucaine and Fluoride)	50
L060	Carboxyhemoglobin	15
L061	CO_2 Content, CO_2 Combining Power, Bicarbonate (measured, not calculated)	6
L062	Chymotrypsin	22

LABORATORY MEDICINE

Code	BIOCHEMISTRY - Cont'd	LMS Units
L063	Copper	40
L064	Cortisol	35
L065	Creatine (includes creatinine)	26
L066	Creatine Phosphokinase	25
L070	Creatine Phosphokinase, fractionation	34
L067	Creatinine (not with L068)	6
L068	Creatinine Clearance	15
L075	Crystal Identification (X ray powder diffraction analysis)	30
L069	Cystine Screening — U	8
L074	Diazepam, Quantitative	40
L072	Digoxin	45
L077	Diphenylhydantoin, Quantitative (phenytoin)	35
L076	Disopyramide	35
L078	Drug Screening, thin layer chromatography	20
L079	Drug Screening TLC + gas liquid chromatography confirmation	75
L085	Electrophoresis, serum — including total protein	36
L086	Electorophoresis, other than serum — including total protein	50
L080	Electrophresis, serum — alone	26
L087	Estradiol	75
L088	Estriol — B	75
L089	Estriol, Pregnancy — U	50
L090	Estrogens, total — U	50
L091	Estrone	75
L092	Ethosuximide, Quantitative	35
L095	Fat, total — F	72
L096	Fat, Differential — F	92
L097	Fat and/or meat fibres (microscopic) — F	6
L098	Fat (microscopic) — U	6
L099	Fatty Acids, free	25
L094	Flurazepam, Quantitative	40
L100	F.S.H. (Pituitary Gonadotrophins)	60
L105	Galactose (per sample)	16
L106	Galactose – 1 – phosphate uridyl transferase (quantitative)	65
L113	Galactose – 1 – phosphate uridyl transferase (screening)	10
L107	Gamma glutamyl transpeptidase	15
L109	Gastric analysis titration (per sample)	7
L110	Globulin (excluded if albumin and/or protein electrophresis done)	10
L111	Glucose, quantitative (not by dipstick)	6
L112	Glucose, semi-quantitative (dipstick if read with reflectance meter)	3
L104	**Glucose tolerance test**	**30**
L103	**Glucose tolerance test in pregnancy**	**24**
L114	Glutathione	20
L115	Glycoproteins	60

LABORATORY MEDICINE

Code	BIOCHEMISTRY - Cont'd	LMS Units
L093	Glycosylated hemoglobin — Hgb A_1	22
L116	Gold	40
L120	Haptoglobin	15
L132	**Hemoglobin A_2 by column chromatography**	**25**
L119	Hexoseaminidase A	15
L121	5H1AA Screening — U	9
L122	5H1AA Quantitation — U	50
L117	High Density Lipoprotein Cholesterol	18
L118	Histamine	90
L123	Homogenistic Acid (Qualitative)	9
L101	Homovanillic Acid, HVA	60
L124	Hydroxy Butyrate Dehydrogenase	10
L125	17–Hydroxycorticosteroids — U	34
L126	17–Ketogenic Steroids — U	40
L127	17–Kestosteroids, total — U	34
L128	17–Kestosteroids, fractionated — U	80
L129	Hydroxyproline — B	25
L130	Hydroxyproline, Total — U	90
L131	Hydroxyproline, Total and Free — U	150
L135	Inulin Clearance Test	40
L136	Insulin	40
L142	Intestinal Enzymes — qualitative	6
L143	— quantitative	22
L137	Iodine Protein Bound (P.B.I.)	21
L139	Iron, Total — with iron binding capacity	34
L141	Iso-Citric Dehydrogenase	15
L145	Lactic Acid (lactate)	27
L146	Lactic Dehydrogenase (L.D.H.), total	10
L147	Lactic Dehydrogenase Fractionation	29
L148	Lead	40
L149	Leucine Aminopeptidase	15
L159	Lidocaine	35
L150	Lipase	22
L151	Lipid (total)	16
L152	Lipids (Thin Layer Chromatography)	30
L153	Lipoprotein, Electrophoresis-not to be charged with L156	34
L154	Lipoprotein, Ultracentrifugation	50
L155	Lipoprotein Lipase (Frederickson)	100
L156	Lipoprotein phenotyping (includes sample appearance, cholesterol, triglycerides, lipoprotein, electrophoresis and interpretation) — not to be charged with L055, L153 or L243	69
L157	Lithium	10
L158	Luteinizing Hormone (LH), chemical (not immunologic)	60
L165	Magnesium	13
L166	Malic Dehydrogenase	15

LABORATORY MEDICINE

Code	BIOCHEMISTRY - Cont'd	LMS Units
L167	Melanin — U	10
L168	Mercury	30
L169	Metanephrines, total — U	75
L170	Metanephrines, fractionated — U	90
L163	Methadone	15
L171	Methemalbumin	21
L172	Methemoglobin	21
L160	Methotrexate (Amethopterin)	35
L175	Methylphenidate, quantitative (Ritalin)	40
L164	Morphine	15
L173	Mucopolysaccharides — U	25
L174	Myoglobin, Qualitative — U	30
L161	N — acetylprocainamide	35
L180	5'—Nucleotidase	25
L181	Occult blood	3
L182	Ornithine Carbonyl Transferase	15
L183	Osmolality (osmolarity)	10
L184	**Oxalic Acid-u**	**40**
L185	P.A.H. Clearance	40
L081	Phenobarbitone	35
L032	pCO_2	8
L033	pO_2 (arterial)	8
L034	pH	7
L035	pCO_2, pO_2 and pH in combination	17
L036	pCO_2, pO_2, pH-calculation of one or more of standard bicarbonate, base excess, etc.	3
L187	Phenothiazines, Qualitative — U	6
L188	Phenothiazines, Quantitative — U	30
L189	Phenylalanine	15
L190	Phosphatase, Acid	15
Note:	L190 — no additional claim may be made for a repeat test using an inhibitor (such as for prostatic acid phosphatase determination).	
L191	Phosphatase, Alkaline	10
L192	Phosphatase, Alkaline fractionation	29
L193	Phospholipids	30
L194	Phosphorus (inorganic phosphate)	10
L195	Plasma Clearing Factor (Baker)	35
L196	Plasma Hemoglobin	15
L197	Porphobilinogen (PBG), screen — U	10
L198	Porphobilinogen (PBG), Quantitative — U	25
L199	Delta-aminolevulinic Acid (ALA), Quantitative — U	25
L200	Porphyrins, screen	10
L201	Porphyrins, Quantitation (copro, proto, uro) — U	60
L202	Porphyrins, Quantitation (copro, proto, uro) — B	75

Code	BIOCHEMISTRY - Cont'd	LMS Units
L203	Porphyrins, Quantitation (copro, proto, uro) — F	90
L204	Potassium	6
L205	Pregnanediol — U	70
L206	Pregnanetriol — U	80
L211	Primidone, Quantitative (Mysoline)	35
L212	Procainamide	35
L207	Progesterone	50
L214	Propoxyphene	35
L213	Propranolol	35
L208	Protein, total — not to be charged with L085 or L086	10
L209	PSP (Phenolsulphonphthalein)	15
L210	Pyruvic Acid (pyruvate)	27
L215	Quinidine	18
L216	Reducing substances, identified by chromatography	30
L220	Salicylate, Qualitative	5
L221	Salicylate, Quantitative	12
L222	SGOT (AST)	10
L223	SGTP (ALT)	10
L225	Automated chemical analyzers with simultaneously functioning channels (single sample) — see Laboratory Preamble, paragraphs 17, 18	18
L226	Sodium	6
L227	Spectroscopic examination (any)	20
L228	Sulphemoglobin	21
L229	Sulphonamides	27
L230	T−4, Total (Thyroxine)	24
L240	Thiocyanates	15
L242	Thyroxine — Binding Globulin	50
L243	Triglycerides — not to be charged with L156	21
L244	Trypsin	22
L250	Urea Clearance	15
L251	Urea Nitrogen (B.U.N.)	6
L252	Uric Acid	6
L253	Urinalysis, routine (includes microscopic examination of centrifuged specimen plus any or all of S.G., pH, protein, sugar, hemoglobin, ketones, urobilinogen, bilirubin)	7
L254	Urinalysis, microscopy alone or one or more parts of L253 without microscopy (may not be claimed with urine culture for the same specimen)	3
L267	Urobilin, Qualitative — U	7
L255	Urobilinogen, Qualitative (not by dipstick) — U	7
L256	Urobilinogen, Quantitative — U	15
L257	Valproic Acid	35
L260	Vitamin A	30
L261	VMA (Vanilmandelic Acid)	60
L265	Xylose Absorption Test (per specimen)	6

Code	**BIOCHEMISTRY – Cont'd**	LMS Units
L266	Zinc	25
L299	Biochemical assays not included above	I.C.
Note:	Biochemical assays other than specifically listed are not a benefit as such until approved by OHIP.	
	RADIO ASSAYS — The following codes apply only if an isotope is used. If alternate non-isotopic biologic, immunologic or chemical method is used, use different code under the appropriate section.	
L307	ACTH (Adrenocorticotrophic Hormone)	120
L300	Aldosterone	120
L691	Alphafetoprotein	45
L304	Aminoglycosides	40
L321	Aminophylline (Theophilline)	40
L305	Androstenedione	75
L322	Anti-DNA	45
L323	Anti-RNA	45
L301	Calcitonin	120
L302	C — AMP (Cyclic Adenosine Monophosphate)	60
L346	C-peptide Immunoreactivity	60
L690	Carcinoembryonic antigen (CEA) (see Laboratory Preamble, paragraph 22)	I.C.
L303	Cortisol	35
L347	Dehydroepiandrostenedione	75
L306	Digoxin	45
L324	Diphenylhydantoin (Phenytoin), quantitative (Dilantin)	35
L310	Estradiol	75
L311	Estriol	75
L312	Estrogens — total — U	50
L313	Estrone	75
L329	Ferritin	45
L308	Folate, serum (not to be billed in addition to L309.)	45
L309	Folate, in red cells, to include serum folate and hematocrit	98
L315	FSH (Pituitary Gonadotrophins)	60
L316	Gastrin	75
L317	Growth Hormone	40
L318	HCG (Human Chorionic Gonadotrophins)	50
L319	Hepatitis associated antigen or antibody radioimmunoassay (e.g. hepatitis B surface antigen or antibody, hepatitis B anticore antibody, hepatitis A antibody) — per assay	45
L919	**Hepatitis associated antigen or antibody radio-immunoassay by secondary laboratory per assay**	**45**
L693	Hormone receptors for carcinoma (to include estrogen and/or progesterone assays)	I.C.

LABORATORY MEDICINE

Code	**BIOCHEMISTRY - Cont'd**	LMS Units
L320	HPL (Human Placental Loctogen)	50
L334	IgE	45
L688	Immune complexes by C1q binding	60
L689	Immune complexes by Raji cell assay	100
L325	Insulin	40
L326	Insulin antibodies	80
L327	Iron binding capacity	24
L328	LH (Luteinizing Hormone)	60
L330	Parathyroid Hormone	120
L343	Phenobarbitone	35
L348	Proinsulin radioimmunoassay	500
L331	Progesterone	50
L333	17—OH Progesterone	60
L332	Prolactin	75
L335	Renin	75
L336	T—3, Total (Triiodothyronine)	40
L337	T—3 Uptake	18
L338	T—4, Total (Thyroxine)	24
L339	T—4, Free — Absolute (includes T—4 total)	50
L340	Testosterone	50
L341	TSH (Thyroid Stimulating Hormone)	50
L342	Thyroxine Binding Globulin (T.B.G.)	50
L345	Vitamin B12	45
L524	Lymphocyte activation (transformation) by Isotope incorporation (limited to 3 mitogens and/or antigens)	200
L585	Radio-Immuno Assays (not included above)	I.C.
Note:	**Radio-immuno assays other than specifically listed are not a benefit as such until approved by OHIP.**	

HEMATOLOGY

L370	Assay of Factors II, V, VII, VIII, IX, X, XI and XII (each)	55
L371	Autohemolysis test	24
L372	Blood film examination (to include differential, red cell morphology and platelet estimate)	10
L374	Blood film — buffy coat preparation — not to be charged with L430	18
L375	Blood film — special stain	11
L376	Bleeding time — Duke method	8
L377	Bleeding time — Ivy method	15
L378	Bone marrow — film preparation	15
L379	Bone marrow — staining (Romanowski and iron)	23

LABORATORY MEDICINE

Code	HEMATOLOGY - Cont'd	LMS Units
L385	Capillary fragility	7
L386	Circulating anticoagulant	10
L387	Clot observation for lysis	7
L388	Clot lysis, dilute whole blood	10
L389	Clot retraction	6
L390	Clotting time (Lee and White)	8
L391	C.S.F. cell count (to include differential)	18
L395	Eosinophil count	8
L396	Platelet count	10
L397	R.B.C. count, excluding manual method (see preamble)	4
L398	Reticulocyte count	13
L399	W.B.C. count	4
L400	Euglobulin clot lysis	20
L401	Fibrinogen, semi-quantitative	6
L402	Fibrinogen, quantitative	28
L403	Factor XIII (Urea solubility test)	5
L404	Fibrinolysis (plate method)	16
L405	Fibrin split products, quantitative	30
L406	Fibrin split products, latex screening	5
L407	Folate, serum	45
L408	Folate, in red cells, to include serum folate and hematocrit	98
L410	G–6–PD screen	10
L411	G–6–PD quantitative assay	65
L412	Pyruvate kinase quantitative assay	65
L415	Haptoglobin	15
L416	Heinz bodies	15
L417	Hematocrit	3
L418	Hemoglobin	4
L419	Hemoglobin electrophoresis to include Hb A_2 fraction	34
L420	Hemoglobin, fetal	20
L421	Hemoglobin, unstable	6
L422	Hemolysins — Ham's Acid Serum test	18
L423	Hemolysins — cold (Donath-Landsteiner)	18
L424	Hemosiderin in urine	11
L430	L.E. Cell prep — not to be charged with L374	18
L431	Kleihauer stain	18
L432	Malaria smear or other parasites	15
L435	Plasmapheresis	50
L436	Platelet function — aggregation, per additive	12
L437	Platelet function — adhesiveness	25
L438	Platelet function — thromboplastic function (PF–3)	28
L439	Preparation of cryoprecipitate (per treatment)	17
L440	platelet concentrates (per treatment)	25
L441	washed red cells	35
L442	leukocyte-poor blood	20
L443	Protamine titration	15

LABORATORY MEDICINE

Code	HEMATOLOGY – Cont'd	LMS Units
L444	Protamine sulphate test	10
L445	Prothrombin time	8
L446	Prothrombin consumption	10
L450	Osmotic fragility	45
L447	Reptilase time	10
L451	Sedimentation rate	4
L452	Sickel cell preparation	14
L453	Sickle cell solubility test (screen)	5
L455	**Special stains for acute leukemia**	**75**
L454	Sucrose hemolysis	18
L456	**Terminal transferase by immunofluorescence**	**75**
L460	Thrombin time	10
L461	Thromboplastin generation test	71
L462	Partial thromboplastin time	10
L465	Vitamin B_{12}, microbiologic, not isotopic	45

BLOOD BANK

(Refer to Laboratory Medicine Preamble, paragraph 19.)

Code		LMS Units
	Antibody identification	
L471	—incomplete antibody (to be claimed only if L482 is positive or doubtful	45
L472	—complete antibody (to be claimed only if L482 is positive or doubtful)	30
L481	Antibody titre per antibody regardless of method used (to be claimed only if either L471 or L472 yielded positive identification. Not to be claimed routinely.)	15
L482	Antibody screening	16
L473	Parallel titration on two specimens to include confirmation of previously detected antibody (see also OHIP Bulletin #4141)	75
L490	Blood group — ABO and Rh_o(D)	13
L492	— crossmatch per unit of blood	10
L493	Blood group — ABO and Rh genotype	40
L494	Blood group per antigen	8
L495	Direct anti-human globulin test	4

IMMUNOLOGY

Code		LMS Units
	Single Gel Diffusion; Nephelometric Quantitative Assays	
L550	Immunoglobulin A, IgD, IgG, IgM	12
	Complement proteins	
L560	Titre — Clq	12
L551	—$C_3(B_1C)$	12
L552	—$C_4(B_1E)$	12
L557	—C_5	12

LABORATORY MEDICINE

Code	IMMUNOLOGY - Cont'd	LMS Units
L558	—C_3 proactivator	12
L561	—C_1-esterase inactivator	12
	Miscellaneous proteins	
L553	— Ceruloplasmin	12
L554	— Transferrin	12
L555	— Alpha-1-antitrypsin	12
L556	— Alpha-2-macroglobulin	12
	Immunoelectrophoresis	
L575	Maximum of 3 antisera per test serum (per antiserum used) —monoclonal gammopathy screen —L chains —H chains	30
L576	Cryoglobulin characterization	30
	Double Gel Diffusion, Qualitative (Ouchterlony) per antigen	
L568	Antibodies to food antigens (milk, wheat proteins), or to fungal antigens (allergic alveolitis screening series) per antigen — maximum of 4 antisera per patient screen	5
L565	Alphafetoprotein screen	5
L567	C_1-esterase inactivator screen	5
L566	Immunoglobulins, L chains, H chains	5
	Miscellaneous Agglutination Reactions (e.g. Rheumatoid factor; antithyroid (thyroglobulin or microsomal); streptolysin screen)	
L500	Screen	6
L900	**Screen by secondary Laboratory**	**6**
L502	Serial tube, 4 or more antigens	30
L501	Titre-serial tube, single antigen	15
L595	Alphafetoprotein — screen	15
L596	Anti-sperm antibodies — screen	20
L597	— titre	40
L660	Cold agglutinins — screen	6
L661	— titre	15
L665	C-reactive protein	6
L655	Pregnancy test	6
L598	Pregnancy test titre	15
Note:	L598 should not be claimed routinely, and may be claimed only if L655 is positive and there are additional medical indications for the addition of the titre.	
	Cellular-Assays	
L533	ATP depletion test	275
L532	Caffein stimulation test	300
L520	Nitroblue Tetrazolium Test — screen for enzyme deficiency	30

LABORATORY MEDICINE

Code	IMMUNOLOGY - Cont'd	LMS Units
L528	Antibody dependent cellular cytotoxicity	200
L529	Naturally occurring cell cytotoxicity	200
L522	Leukocyte chemotactic activity	150
L521	Intracellular leukocyte bacterial killing capacity (Holmes Test) — per organism	100
L523	Leukocyte phagocytic capacity	40
L524	Lymphocyte activation (transformation) by isotope incorporation (limited to 3 mitogens and/or antigens)	200
L525	Lymphocyte surface immunoglobulins by immunofluorescence	200
L526	Lymphocyte T and B cell rosettes	200
L527	Mixed lymphocyte reaction	300
	Complement-kinetic (activity) assays	
L530	Total haemolytic complement (CH50 non-kit)	50
L531	Complement components (activity assays)	60
	Fluorescent Antibody Tests (Immunofluorescent Studies)	
	Serum anti-tissue antibodies (per type of tissue section examined and per serum dilution used irrespective of number of antibodies identified, maximum of 4 slides per serum).	
L544	— anti-nuclear (may include anti nucleolar)	35
L535	— anti-mitochondrial — anti-thyroid — anti-adrenal — anti-smooth muscle — anti-parietal — anti-skin — anti-sperm	50
L545	Protein Deposition in Tissues (per biopsy examined, any number of antiserums, e.g. Immuno-globulin, complement component, fibrinogen and pathinogens, etc.)	75
	Histocompatibility Testing	
L580	— Tissue typing	200
L581	— Cross match	50
L582	— Antibody screening (per panel of 15 antigens)	150
L583	— HLA27 typing	50
	Microbial Immunology	
L659	Antistreptolysin O, 7-tube titrations or microtechnique	25
L662	Complement fixation — screen	20
L663	— titre, single antigen	30
L664	— multiple antigens	50

Code	IMMUNOLOGY - Cont'd	LMS Units
L667	Direct fluorescent antibody (not to be claimed with listings under Microbiology Cultures)	12
L682	— for each additional antibody, add	4
L683	Indirect fluorescent antibody	15
L684	— for each additional antibody, add	5
L668	Heterophile antibodies — screen (slide or single tube) — with or without absorption	5
L670	— with absorption by guinea pig kidney and ox cells, multiple tube titre (Paul Bunnell)	30
Note:	Hepatitis associated antigen or antibody RIA (see L319 under Radio Assays)	
L658	Trichinella antibody	6
L679	Virus antibodies — ELISA technique or hemagglutination inhibition (Rubella)	30
L680	— neutralization test	40
L681	— sucrose gradient separation of IgM + inhibition test	90
N.C.	VDRL	5
L503	Widal slide or tube agglutination	25
	Radioimmunoassays	
	(see listing under Radioassays)	
	Miscellaneous	
L599	Cryofibrinogen — qualitative	5
L600	Cryoglobulins — qualitative	5
L601	Cryoglobulins — quantitative	30
L602	Pyroglobulins — qualitative	5
L604	Serum Viscosity — relative	10
L603	— quantitative	20
	Modifiers	
	(Units in addition to units for basic test where applicable — Immunologic procedures)	
L610	Concentration of sample before testing (any method)	2
L611	Radio-modification of standard technique utilizing isotope-labelled reagents — immunoelectrophoresis anti-Diptheria; — double diffusion anti-insulin — radial diffusion anti-Tetanus	50
Note:	Radio-modifications other than specifically listed under code L611 are not a benefit as such until approved by OHIP.	
N.C.	Preparation of special antigens or antiserums	N.A.B.
N.C.	Special investigations	N.A.B.

LABORATORY MEDICINE

Code	IMMUNOLOGY – Cont'd	LMS Units
	MICROBIOLOGY	
L620	Antibiotic level, serum	40
L621	Antibiotic sensitivity — per organism, max. of 2 per specimen (see Laboratory Preamble, paragraph 25)	9
L623	— M.I.C. — one antibiotic, tube or agar dilution	25
L622	Chlamydia isolation	55
	Cultures (L667, L682 may not be claimed in addition)	
L624	— blood (including aerobic, anaerobic, subcultures, smears) per bottle	30
L625	— cervical, vaginal, including GC culture, Gram smear, yeast indentification (e.q. Germ tube) not to be claimed with L627	25
L639	— fluids (CSF, joint, pleural etc. not exudates)	28
L626	— fungus, including KOH preparation and smear — not to be claimed for the same specimen with L625, L628, L629; includes L653 for fungus	20
L627	— GC culture and smear — not to be claimed with L625	20
L628	— other swabs or pus — culture and smear	25
L629	— sputum — culture and smear	22
L630	— stool, including necessary agglutinations	33
L640	— throat swabs, for streptococcus, screen only	6
N.C.	— screening for diptheria	N.A.B.
L631	— tuberculosis, including ZN or fluorescent smear	55
L632	— animal inoculation	100
L641	— Urine, screening, actual culture without identification — (see Laboratory Preamble, paragraph 6)	7
L633	— urine, pour plate or Miles-Misra quantitation	20
L634	— urine, calibrated loop quantitation	15
L642	Lysozyme inhibition test	13
L635	Pathogenic E coli (as sole procedure in infants only, such as fluorescent staining, not with L630)	5
L656	Penicillinase production	8
L636	Streptococcus grouping, Lancefield method	18
L638	Streptococcus grouping, coagglutination method	12
L637	Virus isolation	50
	Microscopy	
L645	Darkfield (spirochetes)	10
L646	Electron — direct, for viruses	40
L647	— immunoelectron microscopy	60
L648	— after ultracentrifugation	65
L649	— thin section, for virus	130
L650	Parasites and ova (faeces concentration)	20
L654	Parasites and ova, smear only, special stain	20
L651	Pinworm (Scotch tape prep)	5

LABORATORY MEDICINE

Code	MICROBIOLOGY - Cont'd	LMS Units
L643	Smear only, Gram or Papanicolaou stain, as sole procedure (not with L624–L634)	5
L652	Smear only, special stain, e.g. ZN, inclusions, spores, diphtheria	14
L653	Wet preparation (for fungus, trichomonas, parasites. See Laboratory Preamble, paragraph 14.)	3
	ANATOMICAL PATHOLOGY HISTOLOGY, AND CYTOLOGY	
Note:	Do not claim L700 in addition to codes L701 to L724 or L800 to **L829**. The items listed in this section include only the technical component of the various items listed. The professional component for each item where applicable is listed in the following section.	
N.C.	Autopsy, gross and miscroscopic (including CNS as required)	N.A.B.
N.C.	**Referred-in organs, gross and microscopic**	**N.A.B.**
	Chromosome Analysis	
L701	Chromosome banding	70
L702	Karyotype of blood or bone marrow	300
L703	Karyotype of skin or amnion cells	475
	Cytology and Histology	
L704	Amniotic fluid for fetal maturation	8
L705	Aspiration biopsy, (lung, breast, thyroid, etc.)	32
L706	Bronchial washings or brushings, per specimen	14
L707	Buccal or vaginal smear for Barr body	8
L708	Esophageal, gastric or endometrial washings or brushings	14
L709	Esophageal and gastric washings (including collection)	33
L710	Direct smears — oral, larynx, nipple discharge, vulva	13
L711	Fluids (pleural, ascitic, breast cyst, aspirate pericardial, CSF, urine and joint)	13
L712	Fluorescent Y chromosome	8
L713	Cervicovaginal specimen (including all types of cellular abnormality, assessment of flora and/or cytohormonal evaluation)	13
Note:	For professional component use L812.	
L714	Smear for inclusion bodies	8
L715	Smear for eosinophils (nasal, sputum, ocular etc.)	3
L716	Sputum per specimen for general and/or specified assessment, (e.g., cellular abnormality, asbestos bodies, lipid, hemosiderin, etc.)	14
L717	Electron microscopy	225
L726	**Analytical electron microscopy—elemental detection, mapping or electron diffraction, per specimen**	**40**

LABORATORY MEDICINE

Code	ANATOMICAL PATHOLOGY HISTOLOGY, AND CYTOLOGY - Cont'd	LMS Units
	Metabolic bone study	
L723	— morphologic and morphometric assessment	250
L724	— kinetic assessment including fluorescent label studies	30
L725	**X-ray diffraction analysis of calculi**	**30**
L718	Seminal fluid examination (complete) — see Preamble	22
L719	Smear for spermatozoa only (post-operative) see Preamble	7
L720	Surgical pathology	16
L721	Operative consultation — with or without frozen section (up to three specimens)	15
L722	For each specimen over 3, add	8
L727	**Nerve teasing for demyelineation**	**50**
L728	**Histo chemistry of muscle—1 to 3 enzymes**	**40**
L729	**—each additional enzyme per label**	**13**
L730	**Morphometry e.g. muscle fibre, nerve fascicles, cells**	**75**
L731	**Immunoperoxidase technique— per label (max. of 3 per specimen)**	**75**

ANATOMICAL PATHOLOGY, HISTOLOGY AND CYTOLOGY

(Professional components only)

Note: "L" codes L800-L837 inclusive are professional interpretation benefits, they are not applicable to the taking of samples

Code		Professional Fee $
N.C.	Autopsy, gross and micro (including CNS as required)	NAB
N.C.	**Referred—in organs, gross and microscopic**	**NAB**
L800	Blood film interpretation	9.30
L826	**Special stains for acute leukemia, with written report**	**8.80**
Z403	Bone marrow aspiration	22.90
L802	Bone marrow interpretation	31.50
L830	**Terminal Transferase by immunofluorescence**	**8.80**
L803	Chromosome analysis, per case	43.10
	Cytology	
L804	Amniotic fluid for estimation of fetal maturation	2.75
L805	Aspiration biopsy cytologic consultation (lung, breast, thyroid, etc.)	11.50
L806	Bronchial washings or brushings, per specimen	7.00
L807	Buccal or vaginal smear for Barr body	3.40
L808	Direct smears — oral, larynx, nipple discharge, vulva	3.10
L809	Esophageal, gastric or endometrial washings or brushings per complete specimen	7.00

LABORATORY MEDICINE

Code	ANATOMICAL PATHOLOGY, HISTOLOGY AND CYTOLOGY – Cont'd	Professional Fee $
L810	Fluids (pleural, ascitic, breast cyst, pericardial, CSF, urine and joint) per specimen	4.40
L811	Fluorescent Y Chromosome (peripheral blood)	4.40
L812	**Cervicovaginal** specimen (including all types of cellular abnormality, assessment of flora, and/or cytohormonal evaluation)	3.00
	— For technical component, L713.	
L813	**Smear for Inclusion** bodies	4.40
L814	Smear for eosinophils (nasal, sputum, ocular, etc.)	1.35
L815	Sputum per specimen for general and/or specific assessment (e.g. cellular abnormalities, asbestos bodies, lipid, hemosiderin, etc.)	4.40
L816	Electron microscopy, **transmission or scanning** per case **per technique**	**69.70**
L831	**Analytical electron microscopy—elemental detection, mapping or electron diffraction—per specimen**	**34.45**
	Immunofluorescence Studies	
L817	Anti-tissue antibodies, per case	4.40
L818	Protein deposition in tissues, per case	16.20
L819	Seminal fluid examination, complete (see Laboratory Medicine Schedule, Preamble, paragraph 11)	5.90
L820	Smear for spermatozoa only (see Laboratory Medicine Schedule, Preamble, paragraph 11)	2.75
L821	Surgical pathology, sections and report per case	16.20
L822	Operative consultation — with or without frozen section (up to three specimens)	33.30
L823	For each specimen over three, add	16.20
	Synovial fluid analysis	
L824	Description, viscosity and mucin clot	4.40
L825	Identification of crystals by compensated polarized light	9.00
L801	Metabolic bone studies	57.40
L832	**X-ray diffraction analysis of calculi**	**16.20**
L827	Interpretation of carcinoembryonic antigen (CEA)	3.80
L828	Interpretation of RIA for hormone carcinoma receptors (to include estrogen and/or progesterone assays)	4.75
L829	Imprint and/or touch preparation (with or without special stains)	7.00
L833	**Nerve teasing for demyelineation**	**32.50**
L834	**Histochemistry of muscle—1-3 years**	**16.20**
L835	**—each additional enzyme**	**5.40**
L836	**Morphometry e.g. muscle fibre, nerve fiscicles, cells**	**16.20**
L837	**Immunoperoxidase technique—per label (maximum of 3 per specimen)**	**4.40**

ALPHABETICAL INDEX

(See also Table of Contents)

A

- Abdomen:
  - Angiogram 77, 79
  - Pneumogram 77
  - Scan 66, 86
  - Surgery 187, 189
- Abdomino-perineal 182
- Abductor paralysis, injection of teflon 157
- Abortion 206
- Abscess:
  - Alveolar 173
  - Appendiceal 181
  - Bartholin's 203
  - Brain 212
  - Breast 123
  - Bursae 97, 133, 133, 135, 141, 144, 146, 148, 149, 151
  - Epididymis 200
  - Eyelid 226
  - Intra muscular 115
  - Intra-oral 173
  - Ischiorectal 115
  - Kidney 191
  - Liver 185
  - Ludwig's angina 173
  - Orbital 225
  - Palatal 173
  - Palmar 115
  - Pancreas 186
  - Pelvic 187
  - Perianal 115
  - Perinephric 191
  - Perirectal 182
  - Peritonsillar 173
  - Peri-ureteral 192
  - Peri-urethral 197
  - Peritoneal 187
  - Pilonidal 115
  - Plantar 115
  - Prostatic 201, 202
  - Renal 191
  - Retropharyngeal 173
  - Scrotal 200
  - Seminal vesicle 201
  - Septum 155
  - Skene's 203
  - Subcutaneous 115
  - Subfascial 171
  - Testis 199
  - Thyroid 209
  - Vagina 204
  - Vulva 203
- Accessory nasal sinuses 156
- Acetabulum 143, 145
- Achilles tendon 153
- Acne, plastic planing 122
- Acoustic neuroma 211
- Acromion 136, 137
- ACTH Test 96
- Additional charge, surgery 11, 111
- Adenoids, surgery 174
- Adhesions, intestinal 181
- Admission assessments 34, 45, 55
- Adolescent, defined 6
- Adrenal gland, surgery 209
- Adrenal scan 66
- Adrenalectomy 209
- Adult, defined 6
- Advice by telephone 20,33
- Agency, referring 36
- Ages, defined 6
- Alimentation (parenteral) 99
- Allergy:
  - Tests, injections 88
  - Visits 37
- Alveolar abscess 173
- Amniocentesis 110
- Amputations:
  - Cervix 206
  - Ear 229
  - Extremities 128, 150
  - Penis 199
- Amytal test (Wada) 101
- Anaesthesia:
  - Consultations and visits 37
  - Dental 173
  - Diagnostic and therapeutic procedures 88
  - Obstetrical 108

ALPHABETICAL INDEX

- Anaesthesia: Cont'd
  - Premiums 12, 17
  - Services, defined 16
  - Time units 17
- Anastomosis:
  - Arterial 167
  - Epididymis 200
  - Extracranial-intracranial microvascular 211, 214, 215, 216, 218, 219, 220, 221
  - Facial nerve 216
  - Hypoglossal nerve 216
  - Intestinal 180
  - Microlympho--lympho or lymphovenous 171
  - Oesophageal 176
  - Pancreas 186
  - Rectum 183
  - Ureterovesical 193
  - Vas Deferens 201
  - Venous 169
- Anatomical pathology L19, L21
- Aneurysm:
  - Arterial 167, 168
  - Cerebral 211
  - False, groin 168
  - Sinus of Valsalva 164
  - Veins 169
  - Ventricular 164
- Angina, Ludwig's 173
- Angiograms 77, 79, 90
- Angioplasty 79, 90
- Annual health examination 33, 53
- Annual physical examination 34, 45, 54, 55
- Annuloplasty 165
- Anoplasty 184
- Anoscopy 173, 183
- Antabuse insertion 188
- Anterior chamber, sclera 224
- Anterior instrumentation of spine 140, 142, 143, 219, 220
- Anterior release 142
- Anti-coagulant supervision 89
- Antidiuretic hormone test 96
- Antigen challenge test 84
- Antro-oral fistula 157
- Antrostomy — see Sinusostomy 156
- Antrum lavage 156
- Anus:
  - Biopsy 183
  - Rectal manometry 97
  - Sphincter 183
  - Surgery 184
- Aorta 165, 167
- Aortic valve 166
- Aortogram — see Angiograms. 77, 80, 90
- Apex cardiogram 92
- Appendectomy 181
- Appendix — See Surgical Preamble 112
- Arm, cast 127
- Arnold Chiari malformation 212, 220
- Arrhythmia taping 91
- Arterial:
  - A-V fistula 169
  - Anastomosis 166
  - Aneurysm 168
  - Blood flow study 86
  - Blood gas tests 84, 89
  - Cannulation 88, 166
  - Graft 167
  - Puncture 84, 89
  - Transposition 165
- Arteries, surgery 166, 215
- Arteriography—see Angiograms 77, 79
- Arterioplasty 165, 167
- Arteriotomy 165
- Arthrodesis 128, 150
- Arthrogram 77
- Arthroplasty 128, 150
- Arthroscopy. 128, 132, 135, 143, 147, 151
- Arthrotomy 151
- Artificial insemination 97
- Artificial vagina 205
- Arytenoidectomy 157
- Aspirations:
  - Abdomen 187
  - Amniocentesis 110
  - Bladder 195
  - Brain 212
  - Breast cyst 123
  - Bursa 97
  - Cisterna magna 213
  - Hydrocoele 200
  - Joint 97
  - Lumbar 101

ALPHABETICAL INDEX

- Aspirations: Cont'd
  - Lungs and pleura 160
  - Middle ear 229
  - Pericardium 164
  - Spleen 171
  - Subdural tap 214
  - Thyroid cyst 209
  - Transtracheal 158
  - Vitreous 225
- Assessments, defined — See Preamble .. 4
- Assistants, surgical — see definition — Preamble and individual surgical procedures 15
- Astrocytoma 211, 212
- Atresia:
  - Auditory canal 229
  - Biliary duct 185
  - Choanal 156
  - Intestinal 180
- Atrial septal defect 165
- Attendance at delivery 33, 53, 109
- Attendance at labour 109
- Attendance with patient in ambulance. 13
- Attending physician, billing 14
- Audiometry 103
- Auditory ganglion nerve block 100
- Augmentation mammoplasty 124
- Automated laboratory procedures L10
- Automated plasmapheresis 89
- Autonomic nervous system, surgery... 217
- Autopsy L19, L20
- Avulsion fractures 131
- Avulsion, peripheral nerve 217
- Axillary lymph nodes 171
- Axillary sweat glands 117

B

- Baby:
  - Defined—See Preamble 6
  - Newborn care 34, 53
  - Surgical care 33, 53
  - Well baby care 33, 53
- Bacteriology—see Microbiology L18
- Baker's cyst 148
- Balloon septostomy 165
- Baori (bladder flap) 193
- Barron ligation 183
- Bartholin's gland, cyst, abscess 203
- Barton's fracture 135
- B.C.G. inoculation 97
- Bennett's fracture 131
- Bifid 97, 185
- Bilateral operations 112
- Biliary ducts 185
- Biliary tract 97, 185
- Billing, principles of group, etc. 1
- Biochemistry L5
- Biopsies:
  - Abdomen 187
  - Anus 183
  - Bone 127, 129, 132, 135, 137, 140, 143, 146, 147, 149, 151
  - Brain 212, 213
  - Breast 123
  - Bronchial 158
  - Bursa 136
  - Cervix uteri 205
  - Conjunctiva 227
  - Corpus uteri 206
  - Ear canal 228
  - Endometrium 206
  - Intestine 182
  - Joint 129, 132, 135, 143, 147, 151
  - Laparotomy 187
  - Larynx 157
  - Lips 175
  - Liver 184
  - Lung 161
  - Lymph nodes 171
  - Mouth 173
  - Muscle 129, 132, 135, 140, 144, 146, 147, 149, 151
  - Nasal 155
  - Oesophagus 175
  - Orbit 225
  - Ovary 208
  - Palate 173
  - Pancreas 186
  - Penis 199
  - Pericardial, open 164
  - Peripheral nerves 217
  - Peritoneum 187
  - Pharynx 173
  - Pleura, needle and/or surgical 160

ALPHABETICAL INDEX

- Biopsies: Cont'd
  - Prostate 201
  - Rectosigmoid 182
  - Renal 191
  - Salivary glands 173
  - Scalene 171
  - Skin 115
  - Spinal cord 218
  - Stomach 178
  - Temporal artery 215
  - Tendon ... 129, 132, 135, 140, 144, 146, 147, 149, 151
  - Testis 199
  - Thyroid 209
  - Tongue 173
  - Trachea 158
  - Transurethral 194
  - Transvenous endomyocardial 90
  - Urethra 196
  - Uvula 174
  - Vaginal 204
  - Vas deferens 201
  - Vulva 203
- Bladder:
  - Surgery 195
- Blakemore bag 96
- Blalock procedure 165
- Blepharoplasty 227
- Blood:
  - Bank L14
  - Film L20
  - Gas 84
  - Laboratory—see Haematology L12
  - Nuclear medicine 67
  - Transfusions 89
- Body cast 128
- Boils 115
- Bones:
  - Biopsy 140
  - Density measurement 67, 77
  - Fixation 127
  - Fusion 142
  - Graft 127
  - Lengthening 150
  - Marrow 171, L20
  - Plates, etc., removal 127
  - Scan 67
  - Shortening 146
  - Study L20, L21
  - Surgery 129
  - Tumour 129, 137, 152
- Boutonniere 130
- Brachial plexus 100
- Brain scan 67, 85
- Brain surgery 211
- Branchial cyst, sinus, fistula 174
- Breast prosthesis, removal of 123
- Breast reconstruction 124
- Breast surgery 124
- Brent Technique 229
- Bronchi:
  - Endoscopy 158, 160, 175
  - Surgery 158
- Bronchial brushing 80
- Bronchial provocative testing 88
- Bronchial washings L20
- Bronchogram 77, 80
- Bronchopleural fistula 160
- Bronchoscopy 158, 160
- Buckling procedure 225
- Bunions 151
- Burns 117
- Burr holes 214
- Bursae... 97, 133, 135, 139, 141, 144, 146, 148, 149, 151, 152
- Bypass:
  - Gastric 178
  - Graft 95
  - Intestinal 180
  - Long venous 212
  - Pump 163

C

- CSF shunting procedures 215
- Caecostomy 179
- Caecum, Caecopexy 181
- Caesarean section 108
- Calcaneal spur 151
- Calculus:
  - Biliary—see Cholecystostomy etc.. 185
  - Bladder 194
  - Prostate 201
  - Renal 191
  - Staghorn 192

ALPHABETICAL INDEX

Calculus: Cont'd
  Ureter 193
  Urethra 196
Caldwell-Luc 156
Calibration, ureter 194
Callander 146, 147
Calls:
  Fees 33
  Visits, defined 2
Calycectomy 191
Canaliculus 227
Cannulation 88, 163, 166
Cannulization 206
Canthopexy 139
Canthoplasty 139
Capsulectomy 144
Capsulotomy 224
Carcinoembryonic antigen L11, L21
Carcinoma—see individual systems
Cardiac:
  Bypass 163
  Catheterization 89
  Disease, radiotherapy 69
  Massage 163
  Nuclear medicine studies 66
  Pacemaker 91, 164
  Repair 165
  Surgery 164
Cardiography, non-invasive 92
Cardiology:
  Consultations and visits 39
  See Internal Medicine 44
Cardiotomy 164
Cardiovascular & thoracic surgery:
  Consultations and visits 39
  Diagnostic and therapeutic procedures 88
  Surgery 163
Cardioversion 89
Carotid arteries 77, 79, 156, 167, 215
Carotid body tumour 167
Carotid cavernous fistula 212
Carpal tunnel syndrome 129, 216
Caruncle 197
Cast brace 128
Cast material, cost of 127
Casts, plaster—see Fractures 127
Cataract 224
Catheterization:
  Bladder 195
  Cardiac 89, 90
  Coronary 77, 79
  Eustachian 229
  Intracranial 212
  Peritoneal 95
Cautery:
  Anal fissure 184
  Cervix uteri 205
  Cornea 223
  Nasal septum 156
  Turbinates 155
Cerebral aneurysm, neoplasm 211
Cerebral arteriography—see Angiograms 77, 79
Cerebral spinal fluid scan 67
Cerebral spinal leak:
  Localization 156
  Repair 214
Cerebral stereotaxis 212, 77
Certification and reports 36, 59
Cerumen 103, 228
Cervical:
  Angiogram 77, 79
  Disc 141, 218
  Hemilaminectomy 141, 218
  Rib 144, 159, 216
  Stump 206
  Sympathectomy 217
Cervix:
  Biopsy 206
  Cautery 205
  Incompetent, removal of sutures 110
  Mucous penetration test 97
  Surgery 205
Chalazion 226
Chelation of band keratopathy 223
Chemical treatment of minor skin lesions 203
Chemosurgery (Mohs technique) 117
Chemotherapy 98, 160, 187
Chest surgery 159
Child:
  Defined 6
  Disturbed 59
  Surgical care 53

ALPHABETICAL INDEX

Child: Cont'd
  Well child care
  (Annual health exam.) ... 33, 53
Cholangiogram ... 76, 77, 185
Cholecystectomy ... 186
Cholecystoenterostomy ... 186
Cholecystogastrostomy ... 186
Cholecystokinin test ... 97
Cholecystostomy ... 185
Choledochectomy ... 186
Choledochoduodenostomy ... 185
Choledochoenterostomy ... 186
Choledochotomy ... 178, 181, 185, 186
Chondrectomy ... 136
Chordee repair ... 199
Choroid re-attachment ... 225
Chromosome analysis ... L19, L21
Chronaxie ... 104
Chronic care—see also individual specialties ... 34
Ciliary body, surgery ... 224
Circulatory assist device ... 163
Circumcision ... 199
Cisterna magna ... 213
Cisternogram ... 80
Cleft lip nose ... 156
Cleft lip repair ... 175
Cleft palate ... 174
Clinical biochemistry:
  Consultations and visits ... 40
Clinical immunology — see Internal Medicine ... 40
Clinical procedures associated with radiology ... 79
Clonidine Suppression Test ... 96
Closed reduction ... 131, 134, 154
Club foot ... 152
Coarctation, aorta ... 164
Coeliac ganglion ... 100
Colectomy ... 180
College of Physicians & Surgeons of Ontario ... 1, 2
Colles' fracture ... 135
Colon, surgery ... 179
Colonoscopy ... 179
Colostomy ... 181, 179
Colour vision assessment ... 102
Colpectomy ... 204
Colpocleisis ... 205
Colposcopy ... 205
Comedones ... 115
Commissurotomy ... 212, 220
Complications:
  Medical ... 14
  Surgical—see Surgical Preamble ... 111
Compound fractures or dislocations ... 127
Computed tomography ... 77
Concurrent care ... 33
Conduit, uretero-ileal ... 193
Condylomata ... 184, 199, 203
Confinement ... 108
Congenital club foot ... 151, 152
Congenital dislocation, hip ... 145
Congenital ear defect(s) ... 229
Congenital heart shunt procedures ... 165
Congenital naevus ... 116
Congenital vaginal septum ... 204
Conization, cervix uteri ... 206
Conjunctiva, surgery ... 227
Consultations:
  Surgery ... 112
  Defined ... 2
  (see also under specialties)
Contact lens ... 102
Continuous conduction anaesthesia ... 109
Convalescent care—see also individual specialties ... 33
Cooling, gastric ... 179
Coracoacromial ligament ... 136
Cordotomy ... 220, 77
Cornea, surgery ... 223
Coronary arteries—surgery ... 164
Coronary catheterization ... 79, 77
Corpus uteri, surgery ... 207
Cortical audiometry ... 103
Cortriatriatum ... 165
Cosmetic surgery, defined ... 113
Costo-transversectomy ... 141
Counselling ... 35
Cranial angiogram ... 77, 79
Cranial nerves surgery ... 213
Cranial vault reconstruction ... 139
Craniectomy ... 214
Cranioplasty ... 214
Craniosynostosis ... 214
Craniotomy ... 212
Cranium:
  Nerve blocks ... 100

ALPHABETICAL INDEX

- Cranium: Cont'd
  - Surgery 211
- Cricopharyngeal diverticulum 176
- Critical care 92
- Cryopexy—retina, eyelids 225, 226
- Cryosurgery 117, 173
- Cryotherapy 122, 183, 205
- Crystalline lens, surgery 224
- Culdoscopy 188
- Culdotomy 204
- Curettage:
  - Anal Fissure 184
  - Ear 103
  - Uterine 109, 206
- Cutaneous lesions 115
- Cutaneous nerve blocks 100
- Cutaneous surgery 115
- Cystic hygroma 171
- Cystometrogram 106
- Cystoplasty 196
- Cystoscopy, diagnostic 194
- Cystotomy, cystectomy (see bladder) 195
- Cysts:
  - Bakers 148
  - Bartholin's 203
  - Brain 212
  - Branchial 174
  - Dentigerous 173
  - Dermoid congenital 116
  - Dermoid (cornea) 223
  - Mesenteric 188
  - Pancreatic 186
  - Para ovarian 112, 208
  - Pilonidal 117, 115
  - Renal 81
  - Urachal 195
  - Vaginal 204
- Cytology L19, L20

D

- Dacryocystectomy 227
- Dacryocystogram 77, 80
- Dacryocystorhinostomy 227
- Dacryocystotomy 227
- Dark adaptation curve 102
- Data manipulation—nuclear medicine 66
- Debridement 117, 131, 148, 213, 228
- Decannulation 163
- Decompression:
  - Anterior 141
  - Cecortication, lung 160
  - Cyst or abcess 185
  - Gasserian ganglion 215
  - Nerves 141, 216, 218, 230
  - Optic nerve(s) 214
  - Orbit 214
  - Rectum 182
  - Skull 214
  - Volvulus 182
- Definitions 7-9
- Delivery, obstetrical 108
- Denervation 132, 147
- Denervation of gastroecnemius 147, 217
- Dental anaesthesia, surgery 173
- Dentigerous cysts 173
- Dento-alveolar osteotomy 138
- Dermabrasion 122
- Dermatology:
  - Consultations and visits 41
- Dermoid cyst, congenital 116
- Dermoid cyst, cornea 223
- Desensitization, allergy 88
- Dessication 117
- Detention in ambulance 13
- Detention, defined 13
- Diagnostic Radiology 73
- Diagnostic and therapeutic procedures 87
- Diagnostic interview with child 36
- Diagnostic ultrasound 85
- Dialysis:
  - Home 96
  - Peritoneal 95
  - Self care 96
- Diaphragmatic hernia 189
- Diathermy 105
- Differential benefits, defined 15
- Differential intrathecal spinal block 100
- Digestive system surgery 173
- Digital reimplanation 131
- Dilatation and curettage 206
- Dilation:
  - Anal sphincter 184
  - Colostomy 180

ALPHABETICAL INDEX

- Dilation: Cont'd
  - Enterostomy 181
  - Oesophagus 177
  - Punctum lacrimalis 228
  - Rectum 183
  - Salivary duct 175
  - Ureter 192
  - Urethra 198
  - Vagina 205
- Disability, certification of 36
- Discogram 77, 80
- Discotomy 140, 141, 218
- Discs, intervertebral 141, 218
- Discussion with patient, prior, re fees 1
- Dislocations 131
- Dispensing fee 33
- Districhiasis 226
- Disturbed child 59
- Diverticulectomy 196
- Diverticulum:
  - Bladder 195
  - Cricopharyngeal 176
  - Intrathoracic 176
  - Meckel's 181
  - Urethra 197
- Documentation 1
- Doppler 86, 92
- Dorsal sympathectomy 217
- Drugs, cost of 21
- Duodenogram-hypotonic 76
- Duodenoscopy 175, 179
- Duodenum 178
- Dura, surgery 141, 213, 218
- Dye dilution densitometry 90
- Dynamic flow studies 67

E

- Ear, surgery 228
- Ear syringing or curetting 103
- Echocardiography 85
- Echoencephalography 85
- Echography 85
- Ectopic anus 184
- Ectopic kidney 191
- Ectopic pregnancy 208
- Ectropion 227
- Electrocaogulation 116, 184, 194
- Electrocardiography 90
- Electrocautery (see cautery)
- Electrocochleography 103
- Electroconvulsive therapy, (ECT) 105
- Electrocorticogram 101
- Electrode implant:
  - Endocardial 164
  - Intracranial 213
  - Peripheral nerves 217
  - Spinal cord 220
- Electroencephalography 101
- Electrogustometry 104
- Electromyography 104
- Electron microscopy L18, L21
- Electronystagmography 104
- Electrooculogram 102
- Electrophysiologic mapping of heart 164
- Electroretinography 102
- Electrospinal instrumentation 142
- Electrotherapy 105
- Embolectomy 167, 169
- Embolization 80
- Emergency and out patient department 11, 34
- Emergency calls 11
- Encephalocoele, repair 212
- Encephalography:
  - Carotid 167, 215
  - Electro 101
  - Endarterectomy 164
  - Pneumo 80
  - Vertebral 215
- Endocardial cushion 165
- Endocardial electrode 90
- Endocrine 96
- Endolymphatic Shunt 230
- Endometrial biopsy, curettage 206
- Endometrial flushing 97
- Endoscopies:
  - Abdomen 188
  - Anus 183
  - Bladder 194
  - Bronchi 158
  - Cervix uteri 205
  - Colon 179
  - Duodenum 175, 179
  - Ear 228

ALPHABETICAL INDEX

- Endoscopies: Cont'd
  - Fibre-optic 155
  - Gastric 177
  - Intestines 179
  - Joints 132, 135, 143, 147, 151
  - Larynx 157
  - Lungs and pleura 160
  - Mediastinum 160
  - Oesophagus 175
  - Peritoneum 188
  - Prostate 202
  - Sigmoid 182
  - Stomach 177
  - Trachea and bronchi 158
  - Ureter 192
  - Urethra 196
- Endotracheal intubation 93
- Enterocoele, repair 204
- Enterostomy 180
- Enterotomy 179
- Entropion 226
- Enucleation, eyeball 223
- Epicardial electrode 164
- Epididymectomy 200
- Epididymis, surgery 200
- Epidural anaesthesia and injections .. 100, 101, 109
- Epigastric hernia 189
- Epilation:
  - Eyelid 226
  - Facial hairs 122
- Epiphyseal stapling 150
- Epiphysiodesis 150
- Epispadias 199
- Epistaxis—see also Cautery 156
- Ethical billing 1, 2
- Eustachian catheter 229
- Evisceration 189
  - Eyeball 223
- Examination under anaesthesia 88
  - Ophthalmic 223
  - Vaginal 205
- Examination, health 6
- Exchange transfusions 90
- Exenteration, eye 225
- Exercise 90, 105
- Exercise assessment, pulmonary 84
- Exostectomy 151
- Exostosectomy 152
- Exostosis 229, 149
- External ear, surgery 228
- Extra patient seen 11
- Extraction, dental 173
- Extraocular muscles 225
- Extremities 131
- Extrophy 195
- Eye, surgery 223
- Eyeball, surgery 223
- Eyelid lengthening procedure 227
- Eyelids, surgery 226

F

- Facial bone reconstruction 138
- Facial hairs, epilation 122
- Facial nerves 174, 216, 230
- Facial paralysis 138
- Fallopian tube, surgery 208
- Fallot, tetralogy 165
- False labour 108
- Family, psychotherapy 35, 60
- Fascia . 129, 130, 133, 136, 144, 146, 149, 152
- Fascial graft 139
- Fasciotomy 146
- Fecal disimpaction 183
- Fees, prior agreement 1
- Female genital system surgery 203
- Femoral:
  - Artery 168
  - Hernia 188
  - Nerve 100
- Fetoscopy 110
- Fick 90, 230
- Fimbriolysis 208
- Financial responsibility 1
- Finger:
  - Cast 127
  - Nail 122
  - Webbed 122
- First rib, excision 144, 159, 216
- Fistula:
  - Anterior alveolar 174
  - Antro-oral 157
  - Arteriovenous 169

- Fistula: Cont'd
  - Branchial ... 174
  - Bronchopleural ... 160
  - Carotid—cavernous ... 212
  - Gastrocolic ... 178
  - In ano ... 184
  - Injection ... 77, 80
  - Mastoid ... 230
  - Mucous ... 180
  - Oesophago-tracheal ... 177
  - Palate ... 174
  - Perineal urethra ... 197
  - Pleura ... 160
  - Rectal ... 183, 205
  - Suprapubic ... 196
  - Thyroglossal ... 174
  - Uretero-vaginal ... 193, 205
  - Urethral ... 197
  - Urethro-vaginal ... 205
  - Vaginal ... 183, 205
  - Vesical ... 183, 196, 205
- Fitzgerald-Hallpike method ... 104
- Fixation, internal ... 130, 152
- Flaps ... 119
- Fluorescein angiography, angioscopy 102
- Fluoroscopy:
  - Arthrogram ... 77
  - X-ray ... 77
- Foam stability test ... 110
- Foot ... 127, 128, 129, 150, 151
- Foot cast ... 127
- Foraminotomy ... 141, 218
- Foreign Body:
  - Abdomen ... 188
  - Bladder ... 194
  - Brain ... 214
  - Bronchus ... 158
  - Conjunctiva ... 227
  - Cornea ... 223
  - Ear ... 228
  - Heart ... 164
  - Intraocular ... 223
  - Intravascular ... 80
  - Larynx ... 157
  - Lung ... 160
  - Muscle ... 127, 133
  - Nose ... 155
  - Oesophagus ... 175
  - Orbit ... 225
  - Pleura ... 160
  - Rectum ... 183
  - Skin ... 115
  - Stomach ... 177
  - Urethra ... 196
- Fothergill ... 204
- Fractures and dislocations ... 131
- Fractures, orbit ... 139
- Free Island Flaps ... 121
- Fulguration—see Endoscopies ... 184, 179
- Fusion:
  - Bone ... 150
  - Spinal column ... 140

G

- Gallbladder (see cholecystectomy) 186
- Gallium scanning ... 67
- Ganglion, tendon ... 130, 152
- Gasserian ganglion ... 215
- Gastrectomy ... 178
- Gastric by-pass ... 178
- Gastric lavage ... 96
- Gastric secretion studies ... 97
- Gastric series (X-ray) ... 75
- Gastric surgery ... 177
- Gastro-intestinal system:
  - Radioisotope study ... 66
- Gastrochisis ... 189
- Gastrocnemius, denervation ... 147, 217
- Gastrocolic fistula ... 179
- Gastroduodenostomy ... 178
- Gastroenterology:
  - Consultations and Visits ... 42
  - Diagnostic and therapeutic procedures ... 96
- Gastroenterostomy ... 178
- Gastrojejunostomy ... 178
- Gastrorrhapy ... 178
- Gastroscopy, gastrostomy ... 175, 177
- Gastrotomy ... 177
- General and family practice, consultations and visits ... 33
- General assessment, defined ... 4
- General listings—defined ... 7
- General Surgery, consultations and visits ... 43

ALPHABETICAL INDEX

- Genetic counselling ... 36
- Genioplasty ... 138
- Genital System:
  - Female ... 203
  - Male ... 199
- Genitourinary system, radioisotope ... 67
- Glaucoma procedures ... 224
- Glaucoma provocative tests ... 102
- Glenn procedure ... 165
- Glenoid fossa ... 139
- Glioblastoma ... 211
- Glossectomy, Glossoplasty ... 173
- Glucagon test ... 96
- Glucose tolerance test ... 96, L7
- Grafts:
  - Bone ... 130, 138, 152, 155, 174
  - Breast ... 124
  - Carotid ... 215
  - Facial nerves ... 230
  - Internal mammary ... 164
  - Major peripheral nerve ... 216
  - Scleral ... 227
  - Skin ... 120
  - Tendon ... 130
  - Varicose ulcer ... 169
  - Vascular, failed ... 163
- Granuloma, pyogenic ... 115
- Gritti-Stokes ... 146, 147
- Group billing ... 1
- Group psychotherapy ... 35, 59
- Growth hormone exercise stimulation test ... 96
- Gums ... 173
- Gunderson's conjunctival flap ... 227
- Gunshot wounds—see also foreign body 127, 129, 133, 136, 144, 146, 149, 152
- Gynaecology:
  - Consultations and visits ... 49
  - Diagnostic and therapeutic procedures ... 97
  - Surgery ... 203
  - Tests ... 97

H

- Haemangioma ... 80, 116
- Haematapoietic system, radioisotope ... 67
- Haematocoele, scrotum ... 200
- Haematology:
  - Consultations and visits ... 43
  - Tests ... L12
- Haematoma:
  - Breast ... 123
  - Extracerebral ... 213
  - Intracerebral ... 211, 213
  - Muscle ... 115
  - Septum ... 155
  - Skin ... 115
  - Vagina ... 204
- Haemic and lymphatic systems, surgery ... 171
- Haemodialysis ... 95
- Haemoglobin ... 99, L8, L13
- Haemorrhoidectomy, haemorrhoids ... 183
- Hallux rigidus ... 152
- Hallux valgus ... 152
- Halo traction ... 142, 219
- Hand, cast ... 127
- Harrington instrumentation ... 140, 142, 143, 219, 220
- Harrington procedure ... 142
- Hartmann procedure ... 182
- Head, cast ... 127
- Health examination ... 6
- Hearing aid evaluation ... 103
- Heart:
  - Shunt ... 165
  - Surgery ... 164
- Heat therapy ... 105
- Hemi-arthroplasty ... 147
- Hemicolectomy ... 180
- Hemilaminectomy ... 141, 218
- Hemilaryngectomy ... 157
- Hemipelvectomy ... 143
- Hemispherectomy ... 212
- Hepatectomy ... 184
- Hernia:
  - Diaphragmatic ... 189
  - Hiatus ... 176
  - Incarcerated ... 188
  - Inguinal ... 188

ALPHABETICAL INDEX

Hernia: Cont'd
  Umbilical ... 189
  Ventral ... 189
Herniotomy ... 188
Hess screen examination ... 102
High Risk Pregnancy ... 110
Hip:
  Congenital Dislocation ... 145
  Fracture—see Femur ... 147
  Spica ... 128
Hirschsprung's disease ... 182
His Bundle E.C.G. ... 90
Histamine test ... 84, 96
Histology ... 75, L21
Holidays, extra charge ... 34
Holter monitoring ... 91
Home dialysis ... 96
Home visits, defined ... 11
Homes for the aged—see also under specialties ... 35
Homograft, renal artery ... 192
Hormone pellets ... 96
Hormone receptors for carcinoma.... L11, L21
Horseshoe kidney ... 192
Hospital visit, defined ... 18
Huhners' test ... 97
Hunner ulcer ... 194
Hutch ... 193
Hydrocephalus—see Shunting procedures ... 215
Hydrocoele ... 189, 201
Hydrophilic "Bandage" lens fitting ... 102
Hydrotherapy ... 105
Hydrotubation ... 97
Hymenectomy, hymenotomy ... 203
Hyperalimentation ... 99
Hyperbaric therapy ... 93
Hyperhydrosis ... 117
Hypertelorism ... 138
Hyperthyroidism ... 70
Hypertonic saline infusion test ... 96
Hypnotherapy ... 35, 60
Hypoglossal nerve ... 216
Hypophysectomy ... 214
Hyposensitization ... 88
Hypospadias ... 199
Hypotension ... 18
Hypothermia ... 93, 163, 211
Hypotonic duodenogram ... 76
Hysterectomy ... , 108, 207
Hysteropexy ... 207
Hysteroplasty ... 207
Hysterosalpingogram ... 76, 80, 207
Hysterosalpingography ... 207
Hysteroscopy ... 206
Hysterotomy ... 206

I

Ileal conduit ... 193
Ileoinguinal ... 171
Ileum, Ileostomy ... 179, 180
Iliac artery ... 209
Ilioinguinal, iliohypogastric nerve block ... 100
Iliotibial band ... 146
Immunology ... 40, L14
Impedance audiometry ... 103
Impedance plethysmography ... 92
Imperforate anus ... 184
Implant:
  Hormone pellets ... 96
  Intraspinal stimulation electrodes .. 220
  Pacemaker (electrode and pack) 90, 164
Incarcerated hernia ... 188
Incompetent cervix ... 110, 206
Independent consideration, (I.C.) 113
Independent operative procedures (I.O.P.) ...
Infant, defined ...
Inferior vena cava ... 169
Infiltration, lesion ... 98
Infraorbital nerve ... 100
Inguinal hernia ... 188, 189
Injections and Infusions:
  Abdomen: see "Paracentesis"
  Anal ... 183
  Arterial ... 79
  B.C.G. ... 97
  Brachial ... 77
  Bursa, joints or tendon sheath ... 97
  Chemonucleolysis ... 97
  Chest: see "Thoracentesis"

Injections and Infusions: Cont'd
- Cut-down ... 79, 98
- Fistula ... 77, 80
- Haemorrhoids ... 184
- Hypertonic saline ... 96
- Intra-arterial ... 80
- Intradermal ... 98
- Intralesional infiltration ... 98
- Intramuscular ... 98
- Intrathecal spinal ... 100
- Intravenous ... 98
- Joint ... 97
- Keloids ... 98
- Peripheral motor nerves ... 105
- Retrobulbar ... 101
- Shunt apparatus ... 215
- Sinus ... 77, 80
- Subcutaneous ... 98
- Teflon ... 157
- Varicose veins ... 98

Inner ear, surgery ... 230
Innominate artery ... 167
Insufflation:
- Cervix uteri ... 97
- Presacral ... 81
- Vaginal ... 97

Insulin tests ... 96
Insurance:
- Certification ... 36
- Examination ... 20

Integumentary system ... 115
Intensive care:
- Monitoring ... 94
- Neonatal—see also Resuscitation ... 92
- Visits ... 13

Intercostal nerve root block ... 100
Intercostal tube insertion—see Thoracotomy (closed drainage) ... 160
Interdental wiring ... 138, 139
Intermediate assessment ... 33, 53
Internal fixation ... 127, 147
Internal mammary implantation ... 164
Internal Medicine, consultations and visits ... 44
Interpretations:
- Diagnostic and therapeutic procedures . L20
- Fee schedule ... 1
- Laboratory medicine ... L5
- Obstetrics ... 108
- Radiology ... 73
- Surgery ... 113

Interstitial radium application ... 69
Interventriculostomy ... 213
Intervertebral discs ... 141, 218
Interviews ... 36
Intestinal by-pass ... 180
Intestinal conduit examination ... 81
Intestines, surgery ... 179
Intra-aortic balloon ... 163
Intracavitary radium application . 69, 207
Intralesional infiltration ... 98
Intramammary abscess ... 123
Intramammary needling ... 80
Intraocular foreign body ... 223
Intraocular lens ... 224
Intra-oral tumour ... 173
Intrathecal spinal injection ... 100
Intrathoracic diverticulum ... 176
Intrathoracic oesophagus tube ... 176
Intrauterine contraceptive device—(I.U.D.) ... 97
Intrauterine foetal transfusion ... 89
Intravenous—see "Injection"
Introitus ... 203
Intubation:
- Bile duct ... 185
- For resuscitation ... 92
- Stomach ... 177

Inversion, uterus ... 110, 207
Iodine, (P.B.I.) ... L8
Iridectomy ... 224
Iris, surgery ... 224
Ischiorectal abscess ... 115
Isotopes:
- Diagnostic ... 66, 90
- Therapeutic ... 69

Itemized account ... 1

J

Joint fluid examination ... L19, L20
Joplin ... 152

ALPHABETICAL INDEX

K

K wire ... 130
Karyotype ... L19
Kauffman procedures ... 197
Keller ... 152
Keratectomy ... 223
Keratosis ... 115
Kidney surgery ... 191, 192
Knee prosthesis ... 147
Kock ileostomy ... 181
Kole procedure ... 138
Kronlein procedure ... 226
Kyphoscoliosis ... 142
Kyphosis ... 142

L

Laboratory medicine ... L5, L20
Laboratory medicine, physician's office ... 99
Labour:
  Induction, medical and surgical ... 110
  Obstetrical ... 108
Labyrinthectomy, Labyrinthotomy ... 230
Lacerations:
  Artery ... 166
  Brain ... 213
  Canaliculus ... 227
  Cervical ... 109
  Cutaneous ... 118
  Dura ... 213
  Eyelid ... 226
  Kidney ... 192
  Liver ... 187
  Muscle ... 119
  Post-partum ... 109
  Scrotum ... 200
  Spleen ... 187
  Tongue ... 174
  Vaginal ... 109
  Vein ... 169
Lacrimal bypass ... 228
Lacrimal tract, surgery ... 227
Lamellar graft ... 224
Laminectomy—see also Intervertebral discs ... 141, 218
Laminogram ... 77
Laparoscopy ... 188, 208
Laparotomy ... 187, 208
Lapidus ... 152
Laryngectomy ... 157
Laryngogram ... 77
Laryngoplasty ... 157
Laryngoscopy ... 157
Larynx:
  Endoscopy ... 157
  Surgery ... 157
Laser therapy ... 207, 225
Lateral canthal advancement ... 214
Lavage:
  Antrum ... 156
  Gastric ... 96
  Lung ... 160
  Peritoneal cavity ... 187
Law:
  Attendance at court ... 20
  Consultations as required by ... 20
Le Fort ... 139, 205
Learning disabilities ... 36
Leg cast ... 127
Lengthening, bone ... 150
Lens, crystalline ... 224
Lester Jones ... 228
Letter, advice by—see also Reports ... 36
Ligaments ... 130, 133, 152
Ligation:
  Artery ... 166
  Ductus ... 164
  Fallopian tube ... 208
  Varicose vein of labia ... 204
  Vas deferens ... 201
  Veins ... 169
Lipectomy—see Panniculectomy ... 188
Lipoma ... 116
Lipomeningocele ... 221
Lips—surgery ... 175
Litholapaxy ... 196
Liver:
  Scan ... 67
  Surgery ... 184
  Tests—see Laboratory Medicine, Nuclear Medicine
Lobectomy ... 161, 184, 211
Long term institutional care ... 8, 34
Long term terminal cases ... 14

ALPHABETICAL INDEX

Low birth weight care 34, 53
Lower limbs:
  Dislocations 149
  Fractures 147
Ludwig's angina 173
Lumbar sympathetic chain 101
Lumbar:
  Discs 141, 218
  Hemilaminectomy 141, 218
  Nerve block 100
  Puncture 101
  Sympathectomy 217
Lung compliance 80
Lung mechanics, standard or complex . 83
Lungs and pleura:
  Lavage 160
  Scan 68
  Surgery 160
Luque Procedure 142
Lymphangiogram 68, 78, 80
Lymphatic and lymph nodes—see also under Regions 171, 202

M

MacBride 152
Major nerve, peripheral 216
Male genital system, surgery 199
Mallett finger 130
Mallory Weiss, Repair 177
Mammary artery graft, internal 164
Mammary ductography 78, 80
Mammography 78
Mammoplasty 124
Management of hyperalimentation 99
Management of pseudarthrosis .. 130, 152
Mandibular condyle 138
Mandibular nerve block 100
Manipulation:
  Anus 184
  Biliary duct 185
  Intestines 181
  Joints 104, 129, 133, 148, 151
  Lacrimal tract 228
  Rectum 183
  Ureter 192
  Urethra 198
  Vagina 205
Manometry 97, 194
Manual plasmapheresis 89
Marmar Arthroplasty 147
Marrow, bone L20, 171
Marshall-Marchetti 197, 205
Marsupialization:
  Bartholin's 203
  Liver 185
  Pancreas 186
  Pilonidal 117
Massage:
  Cardiac 163
  Therapeutic 105
Mastectomy 124
Mastoid surgery 230
Mastoidectomy 230
Maternal Delivery, attendance at . 33, 53, 109
Maxilla:
  Excision 138
  Fracture 140
Maxillary nerve block 100
Maxillectomy 156
Maximum Stress E.C.G. 91
Mayo 152
McCannell suture procedure 224
McIntosh Arthroplasty 147
Meatoplasty 229, 230
Meatotomy 197
Mechanical evaluation of knee 78
Mechano-therapy 105
Meckel's diverticulum 181
Meconium ileus 180
Mediastinotomy, mediastinum 160
Medical induction, labour 110
Medicine:
  Internal 44
Medico-legal 36
Meloplasty 138
Meningioma 211
Meningocoele, meningomyelocoele 221
Meniscectomy 148
Mental illness, certification 36, 59
Mesenteric artery 167
Mesentery 181
Meso—caval 169
Metabolic studies 90, L20, L21

ALPHABETICAL INDEX

Metabolism ... 96
Mickulicz ... 179
Micro radioscopy, hands ... 78
Microbiology ... 46, L18
Microsurgery ... 157, 211, 214, 215, 216,
  217, 218, 219, 220, 221
Middle ear, surgery ... 229
Mileage—see Traveling time ... 13
Miniature film ... 75
Minimal caloric ... 104
Minor assessment, defined ... 5
Missed appointments ... 2
Mitchell ... 152
Mitral valve ... 165
Mohs technique, chemosurgery ... 117
Moles—see Naevus ... 116
Monitoring, device insert ... 132, 149
Monteggia ... 134
Montgomery "T" tube ... 158
Morcellation procedure ... 214
Morton's neuroma ... 217
Most responsible physician ... 14
Mouth surgery ... 173
Multidisciplinary care ... 14
Multiple:
  Births ... 109
  Fractures ... 131
  Operations ... 111, 112
  Physicians ... 112
Muscles, surgery. 115, 129, 133, 136, 142,
  144, 146, 149, 152
Musculoskeletal system ... 67, 129
Myectomy, myotomy ... 136, 176
Myelogram ... 78, 80
Myeloscopy ... 218
Myelotomy ... 220
Myocardial scan ... 66
Myomectomy ... 207
Myringoplasty ... 230
Myringotomy—see also Tympanoplasty ..
  229

N

Naevus ... 116
Nails, surgery ... 122
Narcoanalysis ... 35, 59
Nasal:
  Biopsy ... 155
  Bones ... 139, 155
  Cautery ... 155
  Polyp ... 155
  Septum ... 155
  Tests ... L21
Nasopharynx, EUGA of ... 155
Neck, surgery ... 171
Needling, crystalline lens ... 224
Neonatal intensive care ... 94
Nephrectomy, nephrostomy,
  nephrotomy ... 191
Nephrology ... 99
Nephropexy ... 192
Nephrotomogram ... 80
Nephrotomography ... 76
Nerve conduction studies ... 104
Nerve:
  Blocks ... 100
  Graft—minor ... 216
  Peripheral ... 216
  Roots ... 132, 147, 217
  Stimulation ... 104, 220
Nervous system surgery ... 211
Neurectomy ... 221
Neurectomy, presacral, ovarian ... 207
Neurology:
  procedures ... 101
  Consultations and visits ... 46
  Diagnostic & therapeutic
  Tests ... 101
Neuroma, Morton's ... 217
Neuroma, acoustic ... 211
Neurosurgery--consultations and
  visits ... 46
Newborn care ... 34, 53
Night calls ... 11
Night service, emergency department.. 34
Nipple transplantation, preservation . 123
Non elective surgical procedures.. 11, 111
Non emergency hospital in-patient
  services—defined ... 33, 53
Non invasive cardiography ... 92
Nose, surgery—see also
  Rhinophyma ... 155
Nuclear medicine:
  Consultations and visits ... 48

ALPHABETICAL INDEX

- Nuclear medicine: Cont'd
  - Tests, in vitro—see under Laboratory medicine
  - Tests, in vivo 66
- Nursing homes—see also under specialties 34

O

- Obstetrics:
  - Anaesthesia 108
  - Care 108
  - Consultations and visits 49
- Obstruction, intestinal 180
- Obturator nerve block 100
- Obturator nerves 217
- Obwegeser 139
- Ocular tumour, localization 68
- Oculo-visual assessment 33
- Oculoplethysmography 92
- Oesophagostomy 176
- Oesophagus:
  - Endoscopy 175
  - Surgery 175, 176
  - Tests 96
- Olecranon 148, 152
- Oligodendroglioma 211
- Omentectomy 207
- Omentopexy, omentum 188
- Ommaya 215
- Omphalocoele 189
- Oophorectomy 208
- Oophorocystectomy 208
- Open heart surgery 163
- Open reductions 131
- Operative delivery 108
- Ophthalmic tests 88
- Ophthalmodynamometry 102
- Ophthalmology:
  - Consultations and visits 50
  - Diagnostic & therapeutic procedures 102
  - Surgery 223
  - Tests 102
- Orbit, surgery 214, 225
- Orbitotomy 226
- Orchidectomy, orchidopexy 200
- Organs of special senses, surgery 223
- Oropharyngeal carcinoma 173
- Orthopaedic surgery:
  - Consultations and visits 50
  - Preamble 127
- Orthoroentgenogram 73
- Os calcis 151
- Ossiculoplasty 230
- Osteochondritis 147
- Osteomyelitis 137
- Osteotomy 130, 152
- Otolaryngology:
  - Consultations and visits 52
  - Diagnostic & therapeutic procedures 103
  - Tests 103
- Otoplasty 142
- Out-of Province surgery 113
- Outpatient and emergency department 11
- Ovary surgery 208
- Oxalic Acid U. Test L9
- Oxymetry 84, 90
- Oxytocin 110

P

- Pacemaker, cardiac 90, 164
- Paediatrics:
  - Consultations and visits 52
- Pain relief 221
- Palate, surgery 173
- Palmar abscess 115
- Pancreas:
  - Scan 67
  - Surgery 186
- Pancreatectomy 186
- Panniculectomy 188
- Pantomography 78
- Papanicolaou smear 49, 97
- Papilloma:
  - Eyelid 115
  - Integumentary system 115
  - Urethral 197
- Paracentesis:
  - Abdomen 187
  - Cornea 223

ALPHABETICAL INDEX

Paraglenoid 136
Paramedical organizations, interview of behalf of 36, 60
Paraovarian cyst 208
Parapharyngeal space lesions 174
Parathyroid angiography 79
Parathyroid gland, surgery 209
Parathyroid scan 66
Paravertebral nerve block 100
Parenteral alimentation 99
Parotid gland, duct 174
Partial Assessment 5
Patch tests 88
Patent ductus arteriosis 164
Pathology:
  Consultation and visits 54
  Laboratory medicine L19
Patient documentation and specimen collection fee L5
Pedicle flap 119
Pelvimetry 76
Penis:
  Surgery 199
  X-ray 78
Pentagastrin stimulation 96
Percutaneous antegrade pyelogram 80
Percutaneous cordotomy 77, 220
Percutaneous nephrostomy 80
Percutaneous pinning 127
Percutaneous removal, foreign bodies .. 80
Percutaneous rhizotomy 221
Percutaneous silicone core needle biopsy, thyroid 209
Percutaneous trans-hepatic cholangiogram, catheter drainage... 80, 185
Perianal abscess 115
Pericardiectomy 164
Pericardium surgery 164
Perimetry, static 103
Perineal:
  Repair 183
  Resection 201
Perineorrhaphy 204
Perineotomy 203
Perinephric abscess 191
Peripheral:
  Angiogram 77
  Arteries 166
  Iridectomy 224
  Nerves 216
  Vascular system, ultrasound 86
  Venogram 79
Perirectal abscess 182
Peritomy 227
Peritoneal:
  Dialysis 95
  Pneumogram 80
  Surgery 187, 188
Peritoneoscopy 188
Peritonitis 181
Permanent feeding line 89
Peter Lord procedure 184
Peyronies disease 199
Phalengectomy 151
Pharyngectomy 174
Pharyngo-laryngectomy 174
Pharyngoplasty 174
Pharynx, surgery 173
Phentolamine test 96
Pheochromocytoma 209
Phlebography 92
Phonoangiography 92
Phonocardiogram 92
Photocoagulation, retina 225
Photographic subtraction 78
Phrenicotomy 159
Physiatric management 57
Physical medicine and rehabilitation:
  Consultation and visits 56
  Diagnostic and therapeutic procedures 104
Physiotherapy, physical medicine 105
Pilonidal abscess, cyst 115
Pituitary 214
Placenta, praevia, retained 109
Placental scan 67
Placentogram 76
Planigram 77
Plantar:
  Abscess 115
  Excision, electrocoagulation 115
Plasmapheresis (automated) 89
Plaster and splints 127
Plastic planing 122
Plastic repair:
  Anus 184

ALPHABETICAL INDEX

Plastic repair: Cont'd
  Bladder 196
  Cervix uteri 206
  Conjunctiva 227
  Fallopian tube 208
  Lips 175
  Penis 199
  Salivary gland and ducts 175
Plastic surgery:
  Consultations and visits 57
  Procedures 122, 226
Plethysmography 83, 92
Pleura:
  Biopsy, needle 160
  Effusion, radiotherapy 70
  Surgery 160
Pleurectomy, pleuroscopy 161
Plication, intestines 181
Pneumoencephalogram 78, 88
Pneumogram 78, 88
Pneumonectomy 161
Pneumothorax 160
Polio vaccine, oral 98
Pollicization 131
Polycythemia 70
Polyps:
  Aural 229
  Gastric 179
  Nasal 155
  Oesophageal 176
  Rectal 182
  Sigmoid 182
Popliteal artery 169
Portable x-ray 78
Post natal care 109
Post operative care 111
Post partum care 109
Pott's procedure 165
Pre-auricular sinus 229
Pre-dental assessment 33
Preamble:
  Diagnostic and therapeutic procedures 87
  General 1
  Laboratory medicine L9
  Obstetrics 108
  Radiology 73
  Radiotherapy 69
  Surgical—see also under various Systems
Pregnancy, care during—see also Obstetrics 108
Premiums 11
Prenatal care 108
Prenatal consultation 53
Prepuce 199
Presacral insufflation 81
Presacral neurectomy 207
Pressure measurements (angiography) 79
Principles of ethical billing 1
Probing, lacrimal duct 228
Proctectomy, proctostomy, proctotomy 182
Proctoscopy 183
Proctosigmoidectomy 182
Proetz displacement 156
Profundoplasty 168
Prognathism 138
Prolapse:
  Fothergill 204
  Intestine 181
  Rectum 183
  Urethral 197
  Vaginal 204
Prostate:
  Biopsy 201
  Fluid, examination L20
  Malignancy, radiotherapy 70
  Massage 106
  Surgery 201
Prostatectomy 202
Prosthesis:
  Joints 135
  Nasal septal 155
  Penile 199
  Testicular 200
  Urethra 197
Provocative testing 88
Pseudarthrosis 127
Psychiatry:
  Consultations and visits 58
  Diagnostic & therapeutic procedures 105
Psychological problem, testing 36
Psychotherapy 35, 59

ALPHABETICAL INDEX

- Pterygium 223
- Ptosis 226
- Pudendal nerve block 18, 100, 101, 109
- Puestow operation 186
- Pulmonary:
  - Artery banding 165
  - Embolectomy 167
  - Function studies 83
  - Valve 165
- Pump bypass 163
- Pyelogram 76, 80
- Pyeloplasty, pyelotomy 192
- Pyloromyotomy (Ramstedt) 177
- Pyloroplasty 178
- Pyogenic granuloma 115

Q

- Quadricepsplasty 146

R

- Rachotomy 141
- Radiation oncology:
  - Consultations and visits 60
  - Procedures 69
- Radioactive Isotope:
  - Diagnostic 66, 102, L11
  - Therapy 70
- Radioactive phosphorus 102
- Radiology:
  - Clinical procedures associated with x-rays 79
  - Consultations and visits 60
  - Diagnostic 73
- Radiotherapy 69
- Radium:
  - Anaesthesia for—see also under Systems in surgery 88
  - Insertion 69
- Ramstedt 177
- Ranula 173
- Receipt, itemized 1
- Recession, muscle 133, 144, 147
- Reconstruction:
  - Acetabular 143
  - Chest 136
  - Fascia and ligaments 130, 134, 146, 153
  - Foot 151
  - Major congenital facial & skull abnormalities 138
  - Mandible 138
  - Skull 138
- Reconstructive surgery, defined 113
- Rectal surgery 182
- Recto vaginal repair 183, 205
- Recurrent dislocations 134
- Reductions:
  - Dislocations 131
  - Fractures 131, 154
  - Mammoplasty 124
  - Prolapse 183
- Referral, defined 13
- Referring physician's services, defined 13,15
- Refraction 33
- Refusion, spine 140, 219
- Regional isolation perfusion 166
- Rehabilitation, management and procedures 57
- Release, tendon 131
- Removal, bone plates, pins etc. 127
- Renal:
  - Artery 168
  - Artery graft 192
  - Autotransplantation 192
  - Cyst puncture 81
  - Function 99
  - Perfusion 99
  - Preservation 99
  - Scan 67
- Repeat surgery 112
- Reports and certificates 36
- Respiratory disease:
  - Consultations and visits 61
- Respiratory function tests 83
- Respiratory system surgery 155
- Resuscitation:
  - Endotracheal intubation 93
  - Life threatening emergency situation 92
- Retained placenta 109
- Retina, surgery 225
- Retrobulbar injection 101

ALPHABETICAL INDEX

Retroperitoneal tumour 192
Retropharyngeal abscess 173
Retropubic
  Prostatectomy 202
  Revision Arthroplasty ... 128, 132, 135, 143, 147, 150
  Urethropexy 205
Rheumatoid arthritis—see also under specific procedure 128
Rheumatology
  Consultations & Visits 62
Rhinophyma 122
Rhinorrhea 156
Rhizotomy 215
Rib resection 144, 159, 160, 216
Roger Anderson apparatus 127
Rosen 197
Rouz-en-y, conversion 178
Royal College of Physicians and Surgeons of Canada 37
Rubin's test 97

S

SMR—see Submucous resection 155
Sacral, coccygeal:
  Nerve block 100
  Teratoma 192
Sacrum, fracture 144, 145
Saline study 85
Salivary ducts, glands 67, 175
Salpingectomy, salpingo-oophorectomy and salpingostomy 208
Saralasin test 96
Saturdays, Sundays, Holidays 34
Saucerization, bone 135, 149
Scalene biopsy 171
Scalenotomy 216
Scalenus anticus 134, 136, 145
Scalp sampling electrode, foetal ECG 110
Scan:
  Adrenal 66
  Brain 67
  Gallium 67
  Liver and/or spleen 67
  Lung 68
  Myocardial perfusion 66
  Pancreatic 67
  Parathyroid 66
  Pericardial effusion 66
  Renal 67
  Tear duct 68
  Thyroid 66
  Whole body 67
Scaphoid:
  Accessory 151
  Fracture 131
Scapula, fracture 137
Scapulopexy 136
Schauta 207
Schilling test 66
Sciatic nerve block 101
Sclera, surgery 224
Sclerotomy 224
Scoliosis 142
Scrotum, surgery 200
Second assistant at surgery 12, 15
Self care dialysis 96
Selverstone clamp 215
Semen study L20
Seminal vesicles, surgery 201
Septal defect, atrial, ventricular 165
Septoplasty 155
Septorhinoplasty 155
Septostomy 165
Septum, nasal, cautery and surgery ... 156
Sequestrectomy 132
Sesamoid bones 152
Sexual dysfunction 35
Shaving, articular surfaces 148
Shortening of bone 146
Shoulder:
  Cuff tear 136
  Recurrent dislocation 137
  Spica 128
Shunting, procedures 169, 215
Sialography 81, 78
Sialolithotomy 174
Sigmoid, surgery—(see Intestines) ... 179
  Silicone rod insertion 130
Sigmoidopexy 181
Sigmoidoscopy 182
Silon mesh 189
Sinusectomy, sinusostomy and sinusotomy 156

ALPHABETICAL INDEX

Sinuses:
  Lavage 156
  Surgery 156
Skeletal survey 75
Skene's gland 203
Skin:
  Flaps 119
  Grafts 120
  Lesions 115
  Surgery 115
  Testing 88
  Thickness measurement 78
Skull:
  Calipers 142, 219
  Fracture 213
  Surgery—see Maxilla, Mandible, Orbit etc. 138, 214
Smith's fracture 135
Somatic nerve block 101
Special care unit 13
Special procedures, radiology 79
Special senses, organs of 223
Special visits 11
Specialist, defined 15
Specialties:
  Consultations and visits 37
Specific assessment, defined 5
Specimen collection L5
Spermatic cord surgery 201
Spermatocoele 200
Sphincter, anal 183
Sphincterotomy 183
Spinal cord:
  Angiography 79
  Deformities 142
  Duraplasty 141, 219
  Fusion 140, 142, 219, 220
  Nerve roots 141, 218
  Perfusion 142, 220
  Surgery 217
Spinothalmic tractotomy 220
Spirometry 83
Splanchnic nerve block 101
Spleen:
  Aspiration 171
  Biopsy (needle) 171
  Scan 67
  Surgery 171, 178, 187
Splenectomy 171
Splenic artery 168
Spleno-palatine ganglion nerve block 101
Splenoportogram 79, 77
Splints, corrective 127
Staghorn calculus 192
Stapedectomy 230
Stapes, surgery 230
Stasis ulcer 169
Static perimetry 103
Stein-Leventhal 208
Steindler flexoplasty 134
Steindler release 152
Steinmann's pin 127
Stellate ganglion nerve block 101
Stereotaxis 77, 212
Sterility investigation L20, L21
Sterilization 201, 208
Sterling Edwards procedure 165
Sternomastoid 136, 216
Sternotomy 159
Stimulation of labour 110
Stimulation of psudoarthrosis 127
Stomach, surgery—see Gastric Stone—see Calculus
  Gall—see Biliary tract 185
  Kidney 191
Strabismus procedures 225
Strangulated hernia 188
Strassman 207
Strength duration and chronaxie 104
Stress incontinence, surgery 197, 205
Stricture 177, 186, 198
Stroboscopy 104
Subconjunctival injection 102
Subcutaneous tissue:
  Injection 98
  Surgery 115
Subdural tap 214
Subfascial abscess—see Intramuscular abscess 115, 171
Submandibular duct relocation 175
Submaxillary gland 174
Submucous resection 155
Subsequent surgery 112
Sub-Tenons capsule injection 102
Superior laryngeal nerve block 101
Supervision:
  Home dialysis 96

ALPHABETICAL INDEX

Supervision: Cont'd
  Limb fitting 143
  Physiatric 57
Supportive care:
  Defined 14
  Fees 33
Supra orbital nerve 101
Suprapubic prostatectomy 202
Surgery, general:
  Consultations and visits 43
Surgical:
  Assistants 16
  Collapse, lung 159
  Induction, labour 110
  Pathology L19, L20
  Preamble 111
  Procedure, defined 113
  Procedures listed 115
Suture, laceration:
  Guidelines 118
  Insertion and removal 118, 174, 188
  Major artery 166
Swan-ganz catheter 89
Sympathectomy 164, 217
Sympathetic nerve block 101
Symphysiotomy 192
Syndactyly 152
Synovectomy 148
Synovial fluid analysis L21
Syringogram 80
Syringomyelia 220

T

TRH and/or LHRH test 96
Tack 230
Talus 151
Tarsal bar 152
Tarsorrhaphy 226
Teaching units 2
Team fees 112
Tear duct scan 68
Teeth 173
Telephone advice 33
Telephone transmitted ECG 91
Teleradiotherapy 69, 106
Temporomandibular joint 138, 140
Tendodesis 153
Tendon surgery 129
Tennis elbow 134
Tenolysis 131, 134, 153
Tenoplasty 130, 134, 146, 153
Tenorrhaphy 130, 134, 153
Tenosynovitis 129
Tenotomy 145
Tensilon test 101
Terminal Care 14
Terms and definitions 2
Testis, surgery 199
Tetanus toxoid 118
Tetralogy of Fallot 165
Thal 177
Therapeutic radiology 60, 69
Thermal burns 117
Thermography 106
Thiersh wire, insertion 183
Third degree laceration 109
Thoracentesis 160
Thoracic angiogram 77, 79
Thoracoplasty 159
Thoracoscopy 160
Thoracotomy 160, 164, 217
Thorax:
  Endoscopy 160
  Hemilaminectomy 141, 218
  Surgery 137
Three "Snip" punctum procedure 227
Thrombectomy 169
Thrombosed haemorrhoids 183
Thymectomy 209
Thymus gland, surgery 209
Thymus transplant 209
Thyroglossal cyst, duct, fistula or sinus 174
Thyroidectomy 209
Thyroid function studies L12, 66
Thyroid gland, surgery 70, 209
Time units, anaesthetists and assistants 12, 15, 17
Tinnitus masker 103
Toenail 122
Toes, cast 127
Tolbutamide test 96
Tomogram 77, 81
Tongue:
  Surgery 173

ALPHABETICAL INDEX

- Tongue: Cont'd
  - Tie 173
- Tonography 103
- Tonometry 33, 102
- Tonsils, surgery 174
- Tooth, extraction 173
- Torek repair 200
- Torkildsen 215
- Torsion of testis 200
- Trachea 158
- Tracheal toilet 93, 94
- Tracheloplasty 206
- Trachelorrhaphy 206
- Tracheo-bronchial aspiration 158
- Tracheostomy 158
- Tractotomy 220
- Transection of bone 136
- Transferral of care 127
- Transfusion, blood 89
- Translumbar aortogram 77 79
- Transluminal angioplasty 79, 90
- Transplant:
  - Artery 167
  - Corneal 224
  - Ectopic anus 184
  - Muscle 136
  - Renal 99, 192
  - Tendon 130, 134
  - Vitreous 225
- Transpubic prostatovesiculectomy 202
- Transtracheal aspiration 158
- Transurethral resection 202
- Transverse scapular nerve block 101
- Travelling time, defined 13
- Treacher-Collins Syndrome, correction 139
- Trichiasis 226
- Trichomonas suspension 49
- Tricuspid valve 165
- Trigeminal ganglion nerve block 101
- Trigger point (infiltration for) 98
- Triplets—(see multiple births) 109
- Tubal interruption 108, 208
- Tuberculosis, tests 98
- Tubes, fallopian 208
- Tumours:
  - Acoustic 211
  - Bone 129, 137, 152
  - Carotid body 167
  - Chest wall 159
  - Glomus 217
  - Humerus 133, 136, 149
  - Intra-oral 173
  - Lid 226
  - Mediastinal 159
  - Metastatic 211
  - Orbital 214
  - Pancreatic 186
  - Pituitary 214
  - Salivary gland and ducts 175
  - Spinal cord 217
  - Testicular 199
  - Unlisted 113
- Tunica vaginalis, surgery 200
- Turbinates, surgery 155
- Twins: (see multiple births) 109
- Tympanoplasty, tympanotomy 230

U

- Ulcer:
  - Corneal 223
  - Peptic 177, 178
- Ultrasonograms 85
- Ultra sound 105, 230
- Ultrasound, diagnostic 85
- Ultraviolet 105
- Umbilectomy 188
- Umbilical arterial and vein catheterization 89, 188
- Umbilical hernia 189
- Undescended testis 200
- Unification, double uteri 207
- Unlisted tumours 113
- Unna's paste 128
- Upper extremities:
  - Dislocations 131
  - Fractures 131, 139
- Ureter, surgery 193
- Ureterectomy 193
- Ureterotomy 193
- Urethra:
  - Biopsy 196
  - Calibration 63
  - Dilatation 198

ALPHABETICAL INDEX

Urethra: Cont'd
  Endoscopy 196
  Fistula 197
  Surgery 196
  Vaginal fistula 196, 205
Urethral sling 197
Urethrectomy 197
Urethrocystogram 76, 81
Urethrogram 76, 81
Urethropexy 197, 205
Urethroplasty 197
Urethroscopy 196
Urethrostomy 196
Urethrotomy 196
Urinalysis, urobilinogen with visit (see Laboratory Medicine) L10
Urinary system, surgery 191
Urology:
  Consultations and visits 63
  Diagnostic and therapeutic procedures 106
Uterine inversion 110, 207
Uterus—surgery (cervix, corpus) — see also Obstetrics 110, 205
Uvula, surgery 174
Uvulectomy 174

V

Vagina, surgery 204
Vaginal:
  Construction 205
  Delivery 108
  Insufflation 97
  Repair 109, 204
Vagotomy 178
Valvotomy, valvoplasty 165
Varices, oesophageal 176
Varicose veins:
  Injections 98
  Surgery 169
Variococoele 201
Vas deferens, surgery 201
Vascular cannulation 84, 89
Vascular ring 165
Vasectomy 201
Vasography 76, 81, 201
Vector ECG 91
Veins, surgery 169
Vena Cava 169
Venipuncture 89
Venography 66
Venous anastomosis 169
Ventral hernia 189
Ventricular aneurysm 164
Ventricular puncture 213
Ventricular septal defect 165
Ventriculo-cisternostomy 215
Ventriculography 212
Ventriculomyotomy 166
Ventriculoscopy 213
Ventriculostomy 215
Vermilionectomy 175
Verruca 116
Vertebral angiogram 77, 79
Vertebral arteries 80, 215
Vesical fistula 196, 205
Vesicostomy 195
Vesiculectomy 201
Vestibular function test 104
Videotape 66, 73, 75
Vidian neurectomy 157
Visits, defined 2
Visual evoked response 103
Visual fields 103
Vital capacity 83
Vitrectomy 225
Vitreous, surgery 225
Volvulus 182
Vulva, surgery 203
Vulvectomy 203

W

Wada 101
Wassmund procedure 138
Water deprivation test 96
Waterston procedure 165
Watkin's interposition 204
Webbed fingers, toes 122
Wedging of splints 128
Well baby care 33, 53
Wertheim's 207
Whipple type operation 186

ALPHABETICAL INDEX

Winged scapula 136
Wounds, Secondary closure 127
  Superficial 117

X

Xanthelasma 226
Xeroradiography 78
X-Rays 73

Z

Ziegler puncture 226
Z-plasty 119
Zygomatic arch 139
Zygomatic fracture dislocation 139